A RESURGENCE OF EUGENICS? THE ROLE OF RACE IN EGG DONATION

RUFARO MOYO MYXRUF001

A minor dissertation for award of the degree of

Master of Social Science

MSocSci

in the department of sociology

Supervisor: Assoc. Prof Amrita Pande

Faculty of Humanities

University of Cape Town

March 2019

The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

Plagiarism Declaration

1. I know that plagiarism is wrong. Plagiarism is to use another's work and pretend that it is my own.
2. I have used the Harvard Convention. Each contribution to, and quotation in this dissertation from the work(s) of other people has been contributed, and has been cited and referenced.
3. This dissertation is my own work.
4. I have not allowed, and will not allow, anyone to copy my work
5. This dissertation has never prior to this been submitted for full or partial fulfilment of a degree.

Signed.

08 March 2019

ABSTRACT

Despite the Human Genome Project in 2000 discovering that there is no hereditary distinction between races, the naturalized bio-centric conception of race continues to pervade our society (Roberts, 2011). One such area where this happens is during the egg donation process. Egg donation is a part of the growing industry of Assisted Reproductive Technologies (ARTs), which clinics employ in the treatment of infertility. Donor agents and clinics often classify their donors using racial categories. This research project sought to discover what role race played in the egg donation process, using racial matching and neo-eugenics as its theoretical frameworks. Ten semi-structured open ended interviews were conducted with nine participants, all of whom work in the field of fertility. The study discovered that the role race plays in the egg donation process is central. Both recipients and donor agents employ racial categories in order to find an egg donor that racially matches the patient, which is the phenomenon of racial-matching. This phenomenon of race-matching is a process of neo-eugenics. Whilst many think of 'better birth' at the mention of the term eugenics, this study makes the argument that racial matching mimics eugenic practices of maintaining the myth of racial purity. Donor agents speak of an 'obviousness' of the use of racial categories, naturalizing race as biological and seemingly legitimizing hegemonic notions of the family. Yet despite the prevalent use of race, donor agents display discomfort in discussing race and employ emotional narratives that speak to the fairy tale of a supposedly racially homogeneous and heterosexual family being made as a means of deflecting possible problematic views of egg donation. The study acknowledges the socio-political issues that often underpin ARTs, which is carefully concealed by narratives of family creation and the search for wellness. The study concludes by reiterating these arguments and making mention of the need for these power dynamics surrounding race to be dismantled to achieve social justice for all.

ACKNOWLEDGEMENTS

There are many people without whom this project would not have reached completion.

To the infertility staff that agreed to be a part of this study, questioning my assumptions and being patient with me. The completion of this thesis would not to be possible without you.

To the administrative staff of the sociology department, Tarayan Stoefels, Lorraine Valentine and Gina Mari Fourie. You do the hard work behind the scenes.

To the sociology department lecturers, particularly Asanda Benya and Jacques De Wet and Bianca Tame. You critiqued my proposal and gave valuable feedback that allowed me to progress. To Faisal Garba, may the force of the bear remain with you. Thank you, for just listening.

To my support structure, Dr Katherine, Dr Qhama, Kim and Mr Moses. Your guidance has been immeasurable and thank you for teaching me to see the gifts of my adversity and the beauty and fulfilment life can still have despite pain.

To Ntshunxeko. You are amazing and you help me try to be the most amazing person I can be. You have picked at my brain with amazing discussions, laughed with me, cried with me and always been there. Providing very much needed emotional support.

To my family, without you and your support I would not have made it. You shape and continue to play a significant role in moulding the person I become. Mummy, Daddy, Bati, Mako, Mbuya Mai Katherine, Mainini Fari, Mainini Chipo, you all made this possible and I will be always grateful.

To my supervisor, Amrita Pande. At the start of this journey you said to me that I was the kind of person who used hardship as a motivation to work harder. You believed in me even when I didn't believe in myself, encouraging me in moments of fear, providing sage advice and guidance. For that I am grateful.

This thesis is dedicated to all of you.

TABLE OF CONTENTS

“A Chadian proverb says: ‘A woman without children is like a tree without leaves’”
((Okonofua F.E., Harris D., Odebiyi A., Kane T., and Snow R.C., 1997) in Dyer, 2007: 73).

“This routinized reinscription of race at the genetic and cellular level in donation programs, which as medicalized organizations offer a veneer of scientific credibility to such claims, is worrisome given our eugenic history” (Almeling, 2007: 338).

INTRODUCTION

"Infertility is defined as the inability to conceive a child after one year of unprotected intercourse" (Elster, 2005: 719). With an estimated 8-12 percent of couples experiencing involuntary childlessness worldwide, infertility is a global problem. In regions such as Sub-Saharan Africa, which is known as the "infertility belt", infertility rates (both primary and secondary) range between 10 to 25 percent (Ryan, 2009: 805). "Africa is a pro-natalist continent" in which marriage is customary and children are of value to people for socio-cultural, personal and economic reasons (Dyer et al., 2004: 964). As a result, the inability to bear children accompanies grave social consequences, making infertility and its treatment a relevant topic of study with the provision of reproductive and social justice in mind. The literature on infertility treatments (Assisted reproductive technologies (ARTs)) has been growing since the 1980s after the first baby was conceived using assisted reproduction in 1978 in the UK (Dow, 2017). Although much of Africa and Sub-Saharan Africa is seen to be resource poor in terms of reproductive technologies, the first IVF procedure took place in South Africa in 1983, merely 5 five years after the first procedure had been done (Dyer and Kruger, 2012). ARTs in South Africa have been expanding since then, with a market of reproductive technologies that attracts both locals and foreigners alike in the private sector (Dyer and Kruger, 2012) and given the specific apartheid and colonial history of South Africa, this makes it an exceptional case for study in Reproductive Technologies and race (Norling, 2015). Yet despite this, the majority of literature on ARTs focuses on Europe and America and the South African literature on ARTs is minimal, allowing this to be a relevant field of inquiry for this study as it attempts to address a geographical gap.

Scholarship in the field of reproductive technologies and race has examined and focused on three phenomenon. First is the disparities that exist around access to ARTs by one's racial group (Chin, 2015; Elster, 2005; Jain, 2006; Guendelman, 2011; Quinn and Fujimoto, 2016; Roberts, 2009). Second, is the reproduction of whiteness that is made possible by these technologies (Nahman, 2016; Schuur, 2016; Roberts, 2012; Quiroga, 2007). Thirdly, scholars also examine how race affects the choices of recipients when choosing donors, indicating that there is often a phenomenon of "racial-matching" or "racial passing" taking place (Pande, 2018 [forthcoming]). This thesis seeks to examine the role that race plays in the process of recipients choosing a desirable donor by seeking out the observations of fertility staff (all staff working in the field of reproductive technologies) in Cape Town, South Africa. The purpose of choosing fertility staff is that given the numerous cases of IVF that have occurred in South Africa, a more general and reliable discovery on the role race plays is to be made by staff who have worked with a variety of patient cases. The insights of staff are not only pivotal, but consulting with them becomes a practical way of accessing the field

of reproductive technologies for study. In addition, Inhorn (2015) and Deomampo (2016) argue that “fieldwork in infertility clinics depends heavily on the goodwill of their gatekeepers” (Deomampo, 2016: 18). Thus, staff are both a convenient and practical means of gaining access to the field. Taking the scholarship on racial-matching and neo-eugenics as theoretical frameworks, the thesis seeks to discover if we may identify this phenomenon (race-matching) taking place in South Africa. The repercussions of this being a resemblance to 19th and 20th century eugenics and a desire to maintain the myth of racial purity, which would thereby indicate a possible resurgence of eugenics by reproductive technologies. Discoveries such as this are relevant to understanding the ways in which race still asserts itself in our post-apartheid dispensation and creating solutions to ensure social justice for all.

FOCAL RESEARCH QUESTIONS OR PROBLEMS

Focal Research Questions

- What role does race play in recipients' choice of a desirable donor according to fertility staff in Cape Town, South Africa?

Sub Research Questions

- Why do egg donor programs and agencies market their donors by separating them into racial categories?

- How do egg donor agents understand race?

- What are the effects of there being options to select donors for infertility treatment based on race?

- How do recipients engage with race in the process of selecting an egg donor? And what, if any, are the social implications that arise from this?

- Are there physical features, understood as racial traits that recipients find desirable in egg donors? [1]

-

[1] When thinking about race in Africa, Harry Garuba distinguishes between two ways in which race is deployed in Africa: the first is the "*global blackness",* the blackness created by modernity and the second is "race as translated and mapped locally" (Garuba, 2008: 1642). In South Africa, the apartheid government, inspired by eugenics and scientific racism (modern conceptions of race), mapped a local manifestation of race in which a racial hierarchy was created using the categories White, Coloured, Indian and Black.
There is a multitude of ways in which race is understood in South Africa which makes the discussion of race difficult but necessary. Throughout this thesis, I argue against a bio-centric conception of race, that is, the employment of race as an essentialist category that is inherent in our genes. Erasmus argues that there are three epistemologies integral to racialization: "the *look*, the *category* and the *gene*" (Erasmus, 2017: XXII). In this thesis, I refer to 'race', 'racial traits' and 'physical features'/'phenotype', in accordance with the *look* and *category* epistemologies that determines two process of racialization in South Africa. This is because it is the *look* and the *category* that donor agents employ and recipients appear to search for in their process of donor selection. The use of the words 'traits' and 'phenotype' in themselves suggest the very conceptualization of race which I argue against. Yet, the purpose of the use of these words is aligned with the categories donor agents employ on their websites and the manner in which them and intended parents *look* for a donor through images as well. It is understood that race, the language and the meanings surrounding it only have meaning due to social processes which have constructed them (Erasmus, 2017: XXII). The employment of this language therefore, is not taken lightly. It is however, a gateway to opening up a dialogue about the manner in which race is employed by fertility clinics.

RATIONALE

As a child I always said to my uncle at any discussion on family that I did not wish to have children. He would always chastise me, noting that children were a blessing and that as I grew older I would change my mind. As a child, I was adamant that I would voluntarily remain child-free. It was only as I became older that I started to interrogate what childlessness means for those who do not choose it. The possible negative social and psycho-social consequences of being without children of one's own in a society that values procreation. As well as the subtle daily pains and trauma of experiencing a longing for a child that may never be. I often drew this parallel to infertility and the psychological effects of it, given how strongly my uncle chastised me.

Unlike other illnesses though, infertility has not always been considered an illness and perhaps this partially explains the little attention it is given. "The social construction of health and illness" is fascinating when examining infertility, because it is not accepted or imposed on the couple until they actively begin to attempt to pursue the social role of being a parent. Infertility hence, is a socially constructed process and state of being in which people come to conceptualize their inability to procreate as an issue (Greil, Slauson-Blevins & McQuillan, 2010: 141). Whilst this thesis, in line with the sociology of illness, understands infertility as a social constructed state in which the inability to have a child becomes defined as a problem, there is an awareness, that infertility has real social consequences for those that suffer with it.

Yet despite my opinion that infertility was not being given the attention I felt it deserved in public policy, I was aware that there were treatments one could seek for this condition. I first encountered talks of IVF, petri-dishes and egg donation at the age of 16 in a biology class. I never thought much of it however, until university when I came across an advert on the notice board of a residence, looking for egg donors and offering compensation of R6000. At the time I thought that it seemed like an unconventional but yet fascinating way for students to make some money, given the enticing sum of money it was at that time. I decided to look up the requirements for egg donation and found that I did not meet the requirements, due to my family history with illness, my own psychiatric diagnosis and my weight. Despite having no real desire to donate my eggs it left me feeling quite inadequate. But what was more peculiar to me was that one of the global agencies made it explicitly clear on their website that there is a high demand for eggs from young, white women.

As time went on, I began to wonder if traits, such as intelligence, appearance, height, and so forth influenced the decisions of recipients when choosing a donor. I came to understand with time through further self-interest reading that my weight left me out of the requirements

because women that are over or underweight have bodies that do not absorb the hormonal medication as effectively. Fine, I thought, that is an understandable medical reason. But what about in other instances? When I read articles and blogs online, I saw that in the United States some couples paid more for white, blonde haired, blue eyed donors at Ivy League institutions, which also left me wondering if the advert had been left at a UCT residence, because recipients prefer donors that are intelligent and UCT is said to be the best university in Africa, with a good number of white students as well. “But intelligence and race do not affect the outcome of successful pregnancy”, I thought to myself. Which led me to my train of thought. What are the physical features that make a ‘perfect’ person who is worthy of reproduction? When we look at societal standards of desirability, do recipients’ choices align themselves with these? Then I started thinking around race in particular and the tremendous role race seems to play in reproductive technologies. Race itself being a phenomenon that has been ruled a social construct with no scientific validity. So why do Reproductive Technologies market their donors in raced categories? Why do people frequently choose a donor based on race? Is it to have a child that looks like them? If so, is this because of the stigma around infertility that leads people to make these choices? What an interesting question for Reproductive Technologies in South Africa, given the apartheid history. So now as the train of thought travels, my thoughts lead me to wonder what role race plays in reproductive technologies and why? What does it mean for South Africa and reproductive justice at large?

LITERATURE REVIEW

In 1978, the first test tube baby was conceived through IVF in the UK and the world of Assisted Reproductive Technologies came into existence (Dow, 2017). Social scientists have been examining these technological approaches to reproduction since their inception. These technologies and their intersection with reproduction are of importance in the social sciences because they are tied to other aspects of life, such as family creation and relatedness, identity, social inequality, globalization and the state of healthcare. Assisted reproductive technologies allow for the examination and placing of reproduction at the centre of analysis. The importance of this being that reproduction and reproductive technologies can serve to indicate persisting dynamics of inequality and power. The review below examines consulted literature on Assisted Reproductive Technologies, then the role race plays in these reproductive technologies according to scholarship and then finally, the literature on reproduction in South Africa will be examined with the aim of indicating the gaps in the literature that this thesis purports to address.

SETTING THE CONTEXT: INFERTILITY AND SCHOLARSHIP ON ITS TREATMENT

It is important to discuss infertility at the beginning of this review, as it sets the context for the emergence of the Assisted Reproductive Technologies and their study within social science. “Infertility is defined as the inability to conceive a child after one year of unprotected intercourse” (Elster, 2005: 719). With an estimated 8-12 percent of couples experiencing involuntary childlessness across all continents, infertility hence, is a global issue. Nachtigall posits that it roughly affects 80 million humans of reproductive age across the world (Nachtigall, 2006). It is difficult to obtain accurate numbers of the prevalence of infertility, but studies indicate that it is most prevalent in developing countries, largely due to untreated Sexually Transmitted Infections (STIs) (Nachtigall, 2006). In Sub-Saharan Africa, which is known as the “infertility belt”, primary and secondary infertility rates range between 10 to 25 percent (Ryan, 2009: 805). Africa is a pro-natalist continent in which marriage is expected and children are of value to people for socio-cultural, personal and economic reasons (Dyer et al., 2004: 964). As a result, the inability to bear children accompanies grave social consequences. Women often bear the negative social consequences that come with infertility because it is often seen as a woman’s issue (though men suffer the social repercussions as well at times) (Dyer et al., 2004: 960; Inhorn and Patrizio, 2015: 8) and leads to stigma and what Inhorn and Patrizio (2015: 4) call a ‘social death’. Procreation resulting in pregnancy remains central to female identity, but for men it is also employed

within gender role pressures as a reflection of virility, the man's role as worker and provider supersedes that of parent (Dyer et al., 2004: 966). Studies show considerable suffering associated with infertility such as marital instability, stigmatization and abuse (Dyer et al., 2004: 960).

In addition to there being disparities in the prevalence of infertility across the globe, other disparities we may identify are with access to the treatments for infertility. In areas of the globe with the highest statistics for infertility, there are not many fertility clinics providing the relevant treatments (Inhorn and Patrizio, 2012; Whittaker and Speier, 2010). In those countries where treatment is available, such as South Africa, it is significantly expensive in the private sector and in the public sector, where government subsidizes the resources are limited and there are long waiting lists (Dyer and Kruger, 2012). In the United States, where ARTs are not subsidized by the government and insurances hardly cover infertility treatments, treatment is restricted to the wealthy that are able to pay out of pocket (Nachtigall, 2006). In addition to scholars examining inequality when it pertains to infertility and access to its treatment, scholars have also examined the dynamic of gender and how it plays out within ARTs.

According to Roberts, these technologies do not subvert the status quo, but rather are conformative (Roberts, 1996: 935). An example of this would be the manner in which these technologies complete the traditional (racially homogenous and heterosexual) nuclear family, by providing a heterosexual couple with a child. These gender norms are reinforced by IVF clinics which only allow heterosexual, married couples to use the reproductive technology services they offer (Roberts, 1996: 936). Feminist who critique these reproductive technologies hence, argue that far from providing reproductive liberation to women, these technologies instead serve men and their desire to continue their genetic line, thereby reinforcing traditional patriarchal roles (Roberts, 1996: 937). Hence, there is a gendered aspect to reproduction that feminists have examined. But in addition, to feminist concerns about the reproductive technologies being oppressive to women, recently scholars have pointed to the gender bias within reproductive technologies, noting that men are often excluded from studies on infertility, ARTs and reproduction at large (Inhorn et al., 2009). Recent ethnographies have responded to this call by Inhorn et al., to examine the position of men in the subject of infertility. Studies such as Inhorn (2009), who examined the male genital cutting of Middle Eastern Men and Goldberg (2009) who examined Israel fertility clinics and discovered that male fertility and notions of sexual intercourse are closely connected. Silence around male infertility in Israel is due to stigmatizing thoughts around sexual dysfunction, defective sperm and ultimately failed manhood (Goldberg, 2009).

Unequal access to infertility treatments has prompted a phenomenon in which infertile persons will travel to other parts of the world to access infertility treatments, due to high costs and/or restrictive laws surrounding ARTs in their home countries for example. This phenomenon is known as “Cross Border Reproductive Care” (CBRC) (Inhorn and Patrizio, 2012). The global entanglements surrounding CBRC has made it a saturated area of study within ARTs and social science. Europe, North America, Latin America, the Middle East and South, East and South East Asia have established infertility treatments hubs for not only locals but travelling patients to receive treatment (Inhorn and Gurtin, 2011). Scholars have found that infertile patients seek infertility treatment abroad for a number of reasons such as treatment in their home country being too expensive or of quality that is not high, excluding certain peoples (such as same-sex couples), long waiting periods or legal restrictions (Inhorn and Gurtin, 2011; Pfeffer, 2011; Whittaker and Speier, 2010). Due to infertile couples also pursuing tourist activities during their stay in the country where they seek treatment, the tourism industries of those countries have expanded (Bergmann, 2011: 282). Certain scholars therefore have termed this phenomenon, “reproductive tourism”, emphasizing that the reproductive technologies are deeply embedded within the global system of capitalism and bears much likeness to other forms of medical tourism (Franklin, 2011; Pfeffer, 2011). However, other scholars such as Whittaker and Speier, 2010 and Inhorn and Patrizio, 2011, find this term very problematic due to the nature of infertility being a painful illness to bear and therefore the term “tourism” which implies enjoyment and holiday is merely an illusion. Inhorn and Patrizio therefore prefer the term “reproductive exile” due to the victimization patients face as a result of not being able to access treatment in their home countries (Inhorn and Patrizio, 2011).

Within this research on CBRC has emerged literature that focuses on the commodification of reproductive tissue in the transnational ART industry (Inhorn, 2011: 92). Sperm, eggs (ova), embryos and commercial surrogates become commodities within the market. Scholars have hence, expressed concerns over the exploitative nature of these technologies. Pfeffer (2011) for instance, argues that due to neoliberal policies of globalization the reproduction of elite women is privileged, while those of poor women creates a pool of “bioavailable” (Cohen, 2005) Global South women risking their health to sell their eggs to receive moderate financial gain. These views on exploitation connect with scholarship which argues that CBRC stratifies reproduction. Stratified reproduction examines how power relations are perpetuated in reproduction, thereby allowing reproduction from certain categories of people alongside the reproductive disabling of others. Hence, creating a situation in which features of some people are desirable, while

those of others are despise (Ginsburg and Rapp, 1995:3). CBRC therefore stratifies reproduction, allowing for the reproduction of relatively wealthy persons from first World nations who have the means to travel for treatment, while disempowering and negating the reproduction of many people in the developing world, as well as racial minorities in Western nations (Franklin, 2011; Inhorn, 2011; Pande, 2014; Pfeffer, 2011; Whittaker and Speier, 2010). In addition, egg vendors also travel internationally to countries treating patients from abroad (Whittaker and Speier, 2010). Bergmann (2011) indicates that these countries attract reproductive travellers and potential egg donors to fertility clinics that seek women whose phenotype represents "whiteness", which is in demand among their international clientele. CBRC hence, "has created gendered job markets for European migrant women" who match the desired racial characteristics of whiteness (Bergman, 2011: 285). Commercial gestational surrogacy is also a topic within this field that has been compelling for travelling patients and researchers. Gestational surrogacy being a process by which a woman gestates and gives birth to a baby with whom she has no genetic link for payment. Many countries have commercial surrogacy markets, but the greatest in scholarship has been India. The Indian commercial surrogacy market has boomed tremendously over the years. Pande argues that commercial surrogacy in India must be perceived and analysed as women's labour to appreciate its role as a survival strategy and to avoid any presumptive perspectives that immediately posit surrogates as victims (Pande, 2010: 971-972). The perspective of surrogacy as labour hence allows us to appreciate the ways in which commercial surrogacy may be not only exploitative, but empowering (Pande, 2010).

Given that this thesis focuses primarily on egg donation, it is valuable to provide insights and discoveries of scholars who have specifically examined egg donation in their studies. Scholars often point to the need for regulation of issues around compensation when it comes to the donation and receiving of eggs (oocytes). For instance, Kenneth Baum argues in his 2001 article, that there have been cases in which donors that meet certain criteria are paid much more than regulations stipulate. ASRM (American Society for Reproductive Medicine) regulations suggest that donors be paid around US$10 000. Baum finds however, that donors deemed tall, attractive and intelligent may be paid up to US$50000 in certain cases. He therefore argues towards greater regulation of the industry (Baum, 2001). Compensation is an issue of contention that scholars have examined, particularly in the field of bioethics. Klitzman and Sauer (2015) argue for greater attention to the compensation and commodification of human eggs, propagating that these ethical concerns are of import because they affect both clinical practice as well as patients. Other scholars who examine the problematic nature of the commodification of human eggs are Klitzman (2016), and

Thompson (2013). Klitzman (2016) makes the argument for ethical concerns regarding compensation and the ways in which genetic tissue becomes commodified, whilst Thompson on the other hand presents a paper that examines the laws and procedures around organ donation and egg donation. She makes an argument against eggsploitation and calls for the contemplation of cases in which people are able to access oocytes but not life-saving organs (Thompson, 2013).

Whether egg donors should be compensated or not and how this must be regulated is an ethical concern, but in the interests of sociological inquiry it is the social ramifications of these genetic materials being commodified that we must shift our attention to. Rene Almeling's article, “Selling Genes, Selling Gender: Egg Agencies, Sperm Banks, and the Medical Market in Genetic Material” examines two egg agencies and two sperm banks, specifically, how recruitment, screening, marketing and compensation takes place. The authour finds that altruistic rhetoric within egg donation more than sperm donation, is a result of gendered norms (Almeling, 2007). In addition, she argues that in the market race becomes biologized, with references such as Jewish eggs and Asian sperm, and that it is race along with hair and eye colour that dominate sorting mechanisms within donor catalogues (Almeling, 2007). Similarly to Almeling, Daniels and Heidt-Forsythe examine the medical market in eggs and sperm, taking a critical stance on the human commodification and arguing that a desire to reproduce ideal babies is entangled along with free market choice (Daniels and Heidt-Forsythe, 2012). The reason this phenomenon of producing the "perfect" child is possible is due to free market choice and the privatization of health in societies. In addition, they also argue about how the agencies for eggs and sperm perpetuate idealized forms of femininity and masculinity, concluding that the unregulated free market in Assisted Reproductive Technologies has facilitated the production of a human hierarchy based on race, class and gender. They define gendered eugenics as determining that individuals that closely fit Western ideals of masculinity and femininity are of greater value for the process of reproduction (Daniels and Heidt-Forsythe, 2012: 720). Krolokke finds that similarly in Spain, altruism and giving are emphasized more for egg donors than the concept of ‘selling’ and that backgrounds of donors are not held in great importance as physical appearance. Phenotypes and being able to replicate sameness (whiteness, hair, and eye colour) is what recipients tend to focus on, thereby reinforcing the phenomenon of race-matching (Krolokke, 2014: 62). Hence, social science scholarship on egg donation points to the perpetuation of gendered and raced norms, in which a hierarchy of humans on the donor market is created, indicating the relevance of the concern around reproductive technologies facilitating a resurgence of eugenics.

There are numerous studies on ARTs, and their morality and ethics, as well as their role in studies on kinship. To provide an exhaustive account of all scholarly work is not possible for the scope and limitations of this project. However, scholarship of importance mentioned above examines ART and inequality, the disparities among access due to class and race positions. Gender and ART, the ways in which ART perpetuates patriarchal family structures and exploits women's reproductive capacity. As well as the prominent field in social sciences on ART of Cross Border Reproductive Care and the ways in which it stratifies reproduction and the creates global entanglements and inequalities within the neoliberal capitalist system of healthcare. Finally, egg donation scholarship is also examined, which indicates raced and gendered hierarchies made possible by the free market of eggs and sperm, leading to a resurgence of eugenics. All of these studies are of import because they examine inequality and persisting power relations, which is the interest of this thesis, particularly with the identity category of race.

THE ROLE OF RACE IN ART

Numerous scholars have examined the role of race in Reproductive Technologies. The scholarship indicates arguments around the disparities of access based on race, the reproduction of whiteness within these technologies, the phenomenon of race-matching when choosing donors, as well as the search for resemblance when choosing donors. These arguments are critical to understanding the role race plays in ART and setting the scene for the direction that this thesis aims to take.

With regards to race and ART, early scholarship on race and reproductive technologies concerned itself with disparities in access to treatment. A dynamic was paved via these technologies in which the reproduction of white women was desirable and the reproduction of black women was restrained. In the interests of white women, black women could become reproductive labourers (Roberts, 1996). In addition, reproductive technologies are employed predominantly by white people. Reproductive technologies are often avoided by Black people, despite them making up the majority of infertile people (Roberts, 1996: 937). This racial disparity in reproductive technologies is not related to infertility rates argues Roberts. People in the United States most likely to be infertile are the poorer, older, Black and poorly educated. Yet IVF services are often employed by highly educated and affluent whites (Roberts, 1996: 939). The racial disparity in use of reproductive technologies appears to be rooted at the heart of the intersections of cultural preference, financial barriers and deliberate professional manipulation (Roberts, 1996: 940). Roberts (1996) finds that few Black people are able to enjoy the benefits of reproductive technologies due to the huge

sums of money required, as well as the privileged lifestyle to maintain arduous and time consuming processes of ultrasound examinations, daily drug injections, blood tests, travels to an IVF clinic, egg extraction and in many cases multiple attempts (Roberts, 1996: 940). The inability of many Black people to access fertility services stems from their wider marginalization in health care. The new reproduction reflects and reinforces power dynamics and inequalities among social groups (Roberts, 1996: 944). Hence, within assisted reproductive technologies there is a double reproduction. There is the reproduction of a child, but there is also a reproduction of racial hierarchies and an enforcement of social relations of power and oppression. Whilst Dorothy Roberts is one of the foremost scholars on race and reproductive technologies, arguments on the racial disparities caused by ARTs are made by many scholars such as Elster (2005), Jain (2006), Guendelman (2011), Chin (2015) and Quinn and Fujimoto (2016).

This subject of racial disparities in ARTs started in the 1980s, when feminists such as Gena Corea spoke of dystopias in which white women's reproduction was of a higher value in perception than that of women of colour. Corea discussed the idea in her work *The Mother Machine* predicting that women of colour would be hired as surrogates for white women at low costs (Roberts, 2009: 783). The opposing relationship of white women and women of colour to Assisted Reproductive Technologies has been critiqued by feminist scholars and has been termed “stratified reproduction” by anthropologists.
Rayna Rapp (Roberts, 2009: 783). Marsha Darling discusses this stratified reproduction stating that these biotechnologies provide a population control for low income women of colour, whilst creating a rubric of 'choice' reserved for ''economically and racially privileged women'' (Darling, 2004b in Roberts, 2009: 784). Roberts, in her earlier work, rather than placing these groups (white women and women of colour) at opposite spectrums, examines them in relation to the trend towards privatization. Population control programs and ART place infertility in the hands of individuals, thus privatizing remedies for social inequity and illness (Roberts, 2009: 784-785). In contrast to before, women of colour are now a part of the market of reproductive technologies and as such as new understanding of the relationship between race and ARTs is needed. Roberts examines the relationship between racism, race and ARTs with the intention of illuminating a new dystopia in which neoliberalism, racism and reproduction converge (Roberts, 2009: 786). Which is a point of import, that whilst race has played a pivotal role in disparities of access to ART, with affluent women of colour being able to access these technologies we must examine privatization. Hence, the intersections of race and class are relevant to the study of ART in South Africa and other parts of the world.

Roberts whilst making arguments around disparities in access to treatment in her earlier works, then goes on to examine how reproductive technologies are facilitating a resurgence of using race in her book, *Fatal Invention: How Science, Politics and Big Business Re-create Race in the Twenty-First Century* (2011). “Fertility clinics solicit egg donations on the basis of race and use race in genetic tests to determine which embryos to implant and which to discard “(Roberts, 2011: Preface). Roberts discusses in her work the phenomenon of race-based medicine and how despite the findings of the Human Genome Project, there has been a resurgence of the use of race (Roberts, 2011), and it is this resurgence of race through reproductive technologies that this thesis aims to explore.

Race therefore, plays a pivotal role in reproductive technologies, despite race being a social construct. Many social scientists have examined the role that race plays in ARTs. Many of these scholars make the argument that ARTs facilitate the reproduction of whiteness (Nahman, 2016; Schuur, 2016; Roberts, 2012; Quiroga, 2007). Elizabeth F. S. Roberts is one of these scholars. In her 2012 book, *God’s Laboratory: Assisted Reproduction in the Andes*, she discusses her ethnography of IVF in Ecuador, discovering that it is widely accepted despite poverty and condemnation from the Catholic Church. She argues that the technological advances in Ecuador are set as a product of Colonial racial history, intersecting with kinship and religion. She makes the argument that working class women of colour are able to gain access to whiteness not through education or professional advancement but through the process of IVF and the care that they receive which is similar to that of whiter women (Roberts, 2012: 75). Labour relations and the hierarchy in Ecuador was based on race, and with ARTs, the reproductive labour women and men partake in, can give them closer access to whiteness (Roberts, 2012: 75). The care within Fertility Clinics is privatized, as the state does not involve itself in the reproductive technologies, hence, Roberts asserts that this private care emphasizes whiteness (Roberts, 2012: 75). It is important to note that whiteness in the Andes, is not necessarily pointing to skin colour, but rather education and cultivation. White/Whiter people are town dwellers, in contrast to the rural, poorly education Indian. Public schooling and medicine is for the poor devalued brown person, whereas by contrast private medicine is for the whiter, valued person (Roberts, 2012: 74). Roberts refers to this care in ARTs as “assisted whiteness”, finding that within the practice of assisted reproduction, whiteness is inscribed into the standard of care received (Roberts, 2012: 75). Therefore, Roberts finds that reproductive technologies in Ecuador that are privatized reproduce whiteness in the standard of care received. Additionally, it is important to note that when scholars state that reproductive

technologies reproduce whiteness, this is not always a reference to skin colour, but can be other attributes such as care, education and so forth that are associated with affluent white people.

Schuur (2016), similarly to Roberts makes the argument about whiteness in an article on surrogacy in Mexico. Hotspots for CBRC were India and Thailand. But due to legislative restraints that have been imposed, international surrogacy is no longer allowed in these countries. Leading to Mexico becoming a hub for accessing surrogacy internationally. She finds that three pertinent issues often came up in the interviews she conducted. The first was despite the cost of surrogacy in Mexico being a third of the price in the United States, many Mexican people did not have access to these reproductive technologies (Schuur, 2016: 249). The second is that fertility doctors often find that the reproductive technologies sell better to Europeans and Americans, due to the fact that Mexico is seen as being overpopulated (Schuur, 2016: 249). Thirdly, doctors and surrogates complain that Mexican people are poorly educated about surrogacy, often having the misconception that the surrogate has to have sexual intercourse with a man in the process (Schuur, 2016: 250). Furthermore, in the Mexican Surrogacy industry, a postcolonial idea of white desirability is often portrayed in their advertisements. Hence, Schuur also finds that there is a reproduction of whiteness in the surrogacy industry of Mexico, both in their advertising and their clientele. Their clients are often international whites, and even in cases where the internationals are not 'white' by skin colour, they are still termed as such due to their affluence. Indicating that whiteness is not only accessible through skin colour, but through class as well and the surrogacy industry in Mexico plays a part in reproducing this whiteness.

Amy Speier (2016) also makes a similar argument in her book, *Fertility Holidays: IVF Tourism and the Reproduction of Whiteness*. She finds that due to the expensive cost of reproductive tourism in the United States, Lower to Middle class Americans will travel to the Czech Republic where they can get blonde, blue-eyed donors at a lower cost (Speier, 2016). Quiroga (2007) argues that ARTs privileging of genetic relatedness, support the creation of a white heteropatriarchal family model in which whiteness may be inherited. "Understanding Whiteness and its power is important to understanding how race is implicated in the use of ARTs as a cultural practice that promoted race-based hierarchies" (Quiroga, 2007: 144). Hence, scholars have made arguments about the ways in which ARTs reproduce whiteness, noting that whiteness is not only a skin colour, but at times, class position and education as well.

Scholars who discuss how ARTs and race intersect also examine the choices surrounding sperm and ova, noting that within these choices there is always a desire to

racially match, racially pass or achieve resemblance in the narratives of clinic staff and patients (Pande, 2018 [Forthcoming]). Several scholars have affirmed the importance of race-matching in their work (Ikemoto, 1995; Krolokke, 2014; Quiroga, 2007; Russell, 2015). Ikemoto (1995) discusses the media attention surrounding reproductive technologies at that time. Noting that the media attention focused on black women selecting white donors and post-menopausal women having babies through reproductive technologies (Ikemoto, 1995: 1014-1015). Yet despite artificial insemination providing the same opportunities for trait selection, the media gave no attention to it. It is only a problem worth giving attention to when black women are choosing white ova (Ikemoto, 1995: 1015) thereby making racial selection evident. Race, therefore, is only interrogated when colour lines are crossed and not when a racial-match is sought out, due to racial matching being seen as an obvious and natural occurrence when using reproductive technologies (Ikemoto, 1995: 1016).

Quiroga argues that the myth of racial purity is maintained by sperm banks by creating careful catalogues of the physical characteristics of sperm donors, which allow for racial-matching to take place. She finds that the purpose for matches are three-fold: the first, is to increase the chances of the child resembling the social parent; the second, to legitimize the family be creating white American's conception of a biological family; and thirdly, to maintain secrecy about the use of an egg donor in the hopes that the child will "pass" as genetically connected to the social parent (Quiroga, 2007: 150). Russell (2015) adds on to this scholarship, noting that the idea that the race of the child must match that of the intended parents is so natural it does not even constitute a choice (Russell, 2015: 605). The influence of race and its biologization in these reproductive technologies is imposed very strongly. In some contexts it was and still is, standard policy to racially-match, or 'ethnically match' as it is sometimes referred to. In the UK, the Human Fertilization and Embryology Authority (HFEA) matching the race of the donor and the recipient used to be official practice up until 2014 (Maung, 2018: 112). Clinics however, continue to racially-match and in European countries such as Spain, Norway and Finland, race-matching remains standard practice (Maung, 2018: 112). The importance of racial-matching is valued tremendously. So much so that until recently, the largest sperm bank in the United States shipped semen in colour coded vials to ease fears of racial "mix-ups" (Russell, 2015: 605-606). The importance placed on racial-matching therefore is high.

In addition to racial matching is what Becker, Butler and Nachtigall (2005: 1301) termed "resemblance talk", from their study in which they examine the challenges of parents who employed donor tissue in the conception of their child. This "resemblance talk" in which

people often draw similarities between the baby and the parents reinforces the normative model of kinship, which places great value on “blood” relations (Becker, Butler and Nachtigall, 2005: 1301). This “resemblance talk” is often unavoidable and parents fear that their child conceived with a donor, may be cast out or stigmatized. Hence, making it difficult for parents to disclose given this emphasis on genetic connectedness (Becker, Butler and Nachtigall, 2005: 1301). This “resemblance talk” therefore, provides us with a reason for why social parents may feel it is necessary to racially match their race and that of the donor’s. Therefore, there is much research on the role of race in ARTs. Scholarship has examined disparities in access to treatment based on race, the reproduction of whiteness and the phenomenon of race-matching when selecting a donor. This thesis interests itself with the phenomenon of racial-matching. This literature therefore, is a pivotal reference point to conducting research on race and egg donation in Cape Town, South Africa. The study addresses in particular the geographical gap within the literature.

SOUTH AFRICA AND THE LACK OF SOCIAL SCIENCE ART LITERATURE

Despite race, class, gender, inequality, privatization, transnational and international reproductive care being major themes that emerge in social science scholarship on reproductive technologies, the literature on ARTs in South Africa is almost non-existent at worst and little at best. Despite the fact that the first test tube baby was first conceived in South Africa in 1983 and the reproductive technology industry has grown vastly since then, the social science literature does not address this area. The disadvantage being that the history of South Africa provides a necessary and relevant platform, particularly with the field of ART and race. This thesis therefore, aims to explore this new terrain, whilst adding to the relatively new and emerging scholarship in this area. Generally, studies on egg donation and race have focused on Europe and America, leaving a geographical gap in the literature to address.

The existing published studies of infertility and reproductive technologies in South Africa are largely short, quantitative studies carried out by academics at health science faculties. One such is Dr. Silke J. Dyer at the Groote Schuur Hospital and University of Cape Town’s medical school. She has conducted a plethora of quantitative studies along with other scholars. One of her articles examines the value of children in African countries (Dyer, 2007). In her study, she examines motivations for parenthood based on infertility studies. She found that whilst there were numerous studies on intentions for parenthood in Western countries, there were not many that examined Africa. She found

that in Africa involuntary childlessness and the negative ramifications that come with it, indicate the importance of children to parents and communities. Support for the negative ramifications of involuntary childlessness are indicated in 2005 and 2009 studies done on the psychological ramifications of infertility, first on women, then on men, indicated that without negating that men experience distress, that women do carry the burden of infertility as far as emotional distress is concerned (Dyer et al., 2005; Dyer et al., 2009: 2825).Hence, indicating the relevance of infertility and in particular its treatment in the South African context as an area of study. Great value is placed on having children within the African context and psychological distress is recorded as a result of infertility.

A 2002 and 2004 study by Dyer et al., examined women's treatment seeking behaviour and knowledge when presenting for treatment at a fertility clinic as well as infertility causes and management respectively (Dyer et al., 2002; Dyer et al., 2004). In addition they examine the emotional and social experiences of childlessness (Dyer et al., 2004: 961). A few informants stated that men did not like to confess to being infertile and that many would instead blame the woman (Dyer et al., 2004: 961-962). The study concludes that procreation resulting in pregnancy remains central to female identity, but for men it is also employed within gender role pressures as a reflection of virility, whilst parenthood is second to the man's role as worker and provider (Dyer et al., 2004: 966). In a later 2008 study it is concluded that men were seen as not being a completely reflexive group due to the fact that men avoid admitting infertility. When it is acknowledged it is a painful experience that accompanies much humiliation and emasculation (Dyer et al., 2008: 354-355). Hence, whilst infertility poses a great challenge to couples, the blame and burden is often placed on women due to gender norms. The bulk of studies on infertility and its treatment in South Africa continue to be predominantly short quantitative studies which indicate the value of children in the African context, gendered norms which place blame for infertility on the woman and the psychological distress that comes with the condition. Few qualitative studies that examine the condition and its treatment have been published.

Published studies discovered on ART in South Africa were minimal. A study on surrogacy has been done by Louw (2013), which examines the appropriateness of the judiciary as the approving authority for surrogacy agreements. In addition, commercial surrogacy is examined and its prohibition is questioned. Louw asserts that there is a need to ensure the constitutional rights of both the commissioning parents and the surrogate mother are respected. These rights include respecting one's dignity, right to freedom and security as well as the right to make decisions with regard to reproduction (Louw, 2013: 568). She argues that with regards to agreements for surrogacy, attention

must be given to what would happen in the case of death, divorce or separation of the commissioning parents and if the child is born with disabilities (Louw, 2013: 573). Another study on South Africa and reproductive technologies was conducted by Dyer and Kruger (2012) which examines the first results generated from the South African Register of Assisted Reproductive Techniques. The reported number of cycles from the South African Register of Assisted Reproductive Technologies indicates that only 6% of the demand is met (Dyer and Kruger, 2011). Other barriers to treatment include geography: many centres that offer ART are in urban areas. In addition, religious beliefs, lack of knowledge and mistrust in an expensive procedure without certain outcome also presents as a barrier to treatment (Dyer and Kruger, 2011: 169). What is most fascinating is that the figures from the South African Register of Assisted Reproductive Techniques indicates that compared to other countries South Africa's fertility industry is doing well and yet there still remains virtually no sociological literature on this phenomenon.

A recent work from South Africa that does address race and emerging genetic technology is a book written by Zimitri Erasmus, entitled *Race Otherwise: Forging a New Humanism for South Africa*. In the book she discusses how race has become a norm and how it is understood and employed in South Africa. Through an interweaving between personal anecdotes and history, Erasmus constantly makes evident the fluidity of race and the meanings that we ascribe to it. In her book she discusses genes, commercialized genetic testing and the manner in which race continues to be naturalized as a biological phenomenon (Erasmus, 2017). She argues that race as a biological phenomenon was created to excuse colonial politics and yet despite this there is a resilience of biological thought around race, tied particularly to genetics. Yet her racial ambiguity and the difficulties and changes with which she has been classified with regards to race, indicates the social construction of race. She argues in the end for a humanism that will be derived through a radical love termed *eros* (Erasmus, 2017). Therefore, Erasmus' book argues against bio-centric conceptions of race and proves to be a relevant piece of literature for this thesis and its conception of race.

Strides to make advancements of social science literature on ART in South Africa is being done by Associate Professor Amrita Pande and doctoral candidate Tessa Moll at the University of Cape Town. A paper has been written by Associate Professor Pande and Tessa Moll, titled, "Gendered bio-responsibilities and travelling egg providers from South Africa". In this article they examine egg providers from South Africa, who travel overseas to go and donate their eggs in other countries. Media coverage of travelling egg providers on popular investigative journalism show, Carte Blanche, depicted these

egg providers as ‘naïve’ women who were being taken advantage of in ‘Third World’ countries away from home. These travelling egg providers took to social media to post their stories with the hashtag #IWasNotEggsploited (Pande and Moll, 2018). In their work, Pande and Moll interview egg agencies and travelling egg providers who counter the narrative in the media which portrayed them as young women being exploited in a foreign place. Pande and Moll make the argument that these travelling egg providers counter gendered assumptions made about them and their victimhood in the media, whilst simultaneously affirming what they refer to as “gendered bio-responsibilities” through altruistic narratives by the egg donors and maternal sentiments by the agency managers (Pande and Moll, 2018).

Moll has since then published an article examining race and gamete donation in South Africa titled, “Making a Match: Curating Race in South African Gamete Donation” (2019). In this article, Moll discusses insights from her ethnographic research in the office of an embryologist, as well as the larger structures and outcomes of “donor matching” in South African fertility clinics (Moll, 2019: 1). Moll argues that in the process of gamete donation race is “enacted” through what is termed “curatorship” by fertility staff (Moll, 2019: 2). This “curatorship” is the racial classifying and organization of the donor’s information. The result being a biologized understanding of race which is inheritable and enacted by fertility staff, whom she refers to as “matchers” (Moll, 2019: 2). These “matchers” in an understanding of shifting relations of power, take up the role of the state in racial classifications in a post-apartheid context. Private fertility clinics hence, become a site of power in the making and reproduction of race, particularly, modes of whiteness in a neo-liberal context of health. Moll posits the idea that whilst these power dynamics and the reproduction of whiteness has been echoed by scholars before her, she makes mention of the tendency hence, to neglect those unknown or “just-about-white” (Moll, 2019: 11). Moll’s article is both relevant and fascinating work for this thesis. Moll’s work, which points to the perpetuation of a biocentric understanding of race through gamete donation is the argument this thesis has examined and made. Whilst Moll examines this through ethnographic methods and theory on curatorship, which differs from the semi-structured interviews and neo-eugenics through race-matching approach of this thesis, the discoveries and arguments Moll makes provide necessary engagement for this thesis and forthcoming social science work on race and reproductive technologies in South Africa.

In sum, the literature on South Africa and infertility largely consists of short quantitative studies. Qualitative literature is lacking. In addition, the published studies on ARTs in South Africa are not many. Hence, there is a huge geographical and methodological gap

in the literature that needs to be addressed. This is not only to have South Africa feature in the literature on reproductive technologies, but also to ensure that power dynamics and inequalities are not repeating themselves in the field of reproduction. It is for this purpose that I endeavour on this project.

THEORETICAL FRAMEWORK: NEO-EUGENICS, THE RETURN OF RACE AND RACEMATCHING

RACE-MATCHING IN ASSISTED REPRODUCTIVE TECHNOLOGIES

There are numerous studies that have been produced on the role of race in Reproductive Technologies. Given the apartheid history of South Africa and the lack of research on this burgeoning market in Africa, examining the role of race is both relevant and necessary. As a theoretical framework for the thesis, the phenomenon of racial-matching holds great importance. Numerous scholars have written on this phenomenon and its importance within Assisted Reproductive Technologies (Ikemoto, 1995; Quiroga, 2007; Russell, 2015; Pande, 2018). Race-matching is in a way a resurgence of eugenics. During the 19th century and early 20th century, eugenics was propagated as a science, asserting that whites must reproduce with whites and blacks must reproduce with blacks, to maintain the myth of racial purity by avoiding mixing the inferior traits of blacks and lower classes with the superior traits of whites (Black, 2003: 7). Hence, racial-matching and neo-eugenics are two intersecting concepts relevant for the study of ART and race in South Africa. Race-matching makes up part of the theoretical framework, and given that it has been elaborated on in the literature review, this theoretical framework section of the project will focus on the history of eugenics, elaborating on how the discourse with regards to eugenics has changed over time to bring us neo-eugenics and why it is such a relevant theory for this project.

NEO-EUGENICS

In order to understand the concept of neo-eugenics, it is adamant that eugenics is expanded upon first. This section will elaborate on the origins of eugenics and how it operated.

In the 19th Century, scientists such as Herbert Spencer, Gregory Mendel and Charles Darwin focused their work on understanding the internal traits of animals, humans and plants which contributed to their differences as well as their ability to survive, reproduce and adapt (Allen, 1983; Allen, 1997: 78; Black, 2003). From this work erupted ideologies of how to improve the human race, rooted in a belief that there were genetically inherited traits that were responsible for the stratifications within society (Black, 2003). The European theorist, Francis Galton, focused on this work with the aim of quantifying evolutionary processes and coined the term, ‘Eugenics’ (Black, 2003; Perkowitz, 2017). Galton desired the use of government policy to restrict marriages between those with desirable and undesirable traits, thereby restricting and eventually eroding the reproduction of those found to have undesirable traits. This is known as negative eugenics (Black, 2003). Black argues that Galton made a shift of

hoping for political backing to religious backing, in the hopes of creating a pure master race by determining which people are fit to procreate together. This is known as positive eugenics. Hence, there were two types of eugenics as argued by Black, negative eugenics, in which those deemed genetically inferior were prevented from reproducing and positive eugenics, in which those who were genetically superior were encouraged to reproduce amongst themselves in the creation of a pure, master race (Black, 2003).

Eugenicists often described their ideology using garden metaphors, stating that society is like a garden which is in need of weeding. Whilst eugenics was widespread, in differing locations what was deemed a 'weed' differed (Dyck, 2014: 7). British eugenics concentrated on poverty and class conflicts, Canadian eugenics focused on race, class and intelligence, with migration, deeming the 'foreigner' as undesirable, European and American eugenics focused primarily on race (Dyck, 2014: 7). American and German eugenicists employed a biological understanding of race in their programs. At the core of eugenics lay a desire to exert power and control over those deemed undesirable within the national plan and whilst eugenics presented itself as a science with the interests of health and nationalism in mind, it was in fact a means of ensuring the maintenance of the myth of racial purity (Dyck, 2014: 8). In the 19th and 20th centuries, Western Nations embraced eugenics, firmly believing that lower classes and minorities were genetically inferior and therefore, their offspring would also have these genetically inferior traits (Black, 2003: 7). Negative eugenics was strongly spearheaded by scholar and head of Eugenics Record Office, Charles Davenport and much funding was put into the research and implementation. Even prior to this, criminals and those admitted in psychiatric hospitals were already being sterilized as a means of preventing the spread of their "inferior genes" (Allen, 1997: 80; Black, 2003).

This movement reached its peak during the late 19th and early 20th century, culminating in the Nazi-led Holocaust. The Holocaust highlighted the scale and severity of dire consequences of eugenic thinking and its manipulation (Dyck, 2014: 9). The link between eugenics and genocide was popularized in the public mind and for decades to follow eugenics was linked to Nazism. The Holocaust changed the language used with regards to eugenics and the direction of the movement, such that many scholars are convinced that eugenics ended with Nazi Germany after 1945. However, while the formal application of eugenics ended, there was a shift in language and application to accommodate the change in reproductive politics (Dyck, 2014: 10-11). In the latter half of the 20th century the discourse changed to birth control, population control, and access to healthcare, disability and reproductive technologies. Discussions about choice and the complexities of genetics and a rising neoeugenics were given way to by the new Reproductive Technologies and prenatal screening. Scholars were divided. One camp made the argument that the human rights,

reproductive rights and rise of second-wave feminism were posing challenges to population control and they defended the scientific contribution of genetic science and the new technologies. The other camp of scholars problematized the categories of 'ability' and 'disability', ultimately repoliticizing reproductive technologies, genetic screening and hereditary medicine, whilst offering relevant complexity to the history of medicine and the ways in which these new technologies were giving rise to eugenics in a different form (Dyck, 2014: 11). While the former camp and many scholars would argue that eugenics ended with the Second World War in light of the atrocities of the Holocaust, I would agree with the latter camp and the idea that eugenics never truly left us, but simply took a different form.

Whilst scientists eventually came to the conclusion that eugenics was merely pseudoscientific racism, the truth is that eugenics has not entirely left us. We need look no further than Murray and Herrnstein's 1994 publication of *The Bell Curve*, a controversial piece of work, in which the argument is made that black people are less intelligent than white people. Eugenics therefore, is never too far from reach, and with the advancement of genetic technologies, some scholars have found that a process of neo-eugenics is able to take place. In her article, "Donor Insemination: Eugenic and Feminist Implications", Allan Hanson points out that one of the concerns of ART lies in their use for positive eugenics. As they become safe and affordable, people may wish to "improve" their offspring by endowing them with desirable traits. Allan Hanson argues that within the politics of reproduction this is one of the central concerns, the use of reproductive technologies for positive eugenics (Allan Hanson, 2001: 287). Whilst biomedical establishments hail the arrival of the genetic technologies as tools to fight off genetic disease and disability, there is the concern that people may employ these technologies to enhance the intelligence, athletic skill and other characteristics deemed desirable (Allan Hanson, 2001: 288; Sandel, 2004). In their work, Daniels and Heidt-Forsythe (2012) examine a pool of over 1500 donors between the years of 2006 and 2008. They discovered in their study what they term a gendered eugenics, in which recipients preferred the tissue of donors that fit the conception of Western ideals of masculinity and femininity (Daniels and Heidt-Forsythe, 2012). For men these were the donors who mainly matched idealized traits of race, class and masculinity, achieved above average grades, have leaner figures and are above average height (Daniels and HeidtForsythe, 2001: 727). For women they discover there is a preference for tall, thin and racially whiter women, with above-average education than other women their age (Daniels and Heidt-Forsythe, 2001: 732). This is not only a phenomenon of Western countries with these technologies, in India, where the reproductive market is booming, Sarojini, Marwah and Sanoi, find that the genetic technologies in Asia are being used for sex selection of males (2011: 7).

While reproductive technologies facilitate positive eugenics and the myth of racial purity through the phenomenon of race-matching, sterilization and contraceptives through population control programs facilitate the negative eugenics of today, lying within a discourse of the idea that having many children is what makes poor people poor (Roberts, 1997). Melinda Gates has stated that contraception is one of the “greatest antipoverty innovations in history” (Gates, 2017) and France’s President, Emmanuel Macron has said that African women would choose to have reproduce less if they were given access to education and family planning (The Gaurdian, 2018). In South Africa in recent years it was revealed that 22 HIV positive women were involuntarily sterilized (Strode, Mthembu and Essack, 2012). In addition, problematic public discourses about black women being hyper-fertile and their 'welfare babies' are still prevalent (Roberts, 1997). Pande, who examines surrogacy in India, has also discussed neo-eugenics, stating that currently, neo-eugenics is

“the new, subtle form of eugenics whereby the neoliberal notion of consumer choice justifies promotion of assisted reproductive services for the rich and, at the same time, by portraying poor people (often in the global South) as strains on the world’s economy and environment justifies aggressive anti-natal policies” (Pande, 2015:7).

Neo-eugenics hence, is an interesting term used to describe the manner in which eugenics presents itself today. Eugenics never ended in 1945, but instead the language and discourse simply changed and continues to conceal itself behind humanitarian ideals of alleviating poverty and healthcare.

Hence, as one of my two theoretical frameworks, I use neo-eugenics. For the purpose of this thesis, I will be employing and expanding upon Pande’s definition. Seeing neo-eugenics as the promotion of reproductive technologies for the rich and anti-natal policies for the poor, whilst also understanding that amongst the use of reproductive technologies is not only the quest for ‘better birth’ as the term eugenics implies, but also reinforcements of the myth of racial purity with regards to race-matching. My intention is to investigate whether Assisted Reproductive Technologies in Cape Town, in particular, egg donation, facilitates a process of neoeugenics at the stage of selecting a donor.

RESEARCH METHODS

RESEARCH DESIGN

Sampling: Of the 3 fertility clinics and 4 egg donor agencies in Cape Town, staff were interviewed from 2 fertility clinics and 3 egg donor agencies, thus making the study almost exhaustive. Yet whilst the study collected data from almost all fertility clinics and egg donor agencies in Cape Town, the findings of the study are not presented as an all-encompassing truth. To do so would be very reductionist. Semi-structured, open ended interviews were conducted with fertility staff about their observations of recipients' desires, what they generally seek and how they engage with race in the process of selecting an egg donor. Many of the contacted staff were forthcoming and willing to participate in the study. There was an acknowledgement from the beginning of the project that race and infertility are sensitive topics to talk about. Hence, an approach that emphasized empathy, a willingness to learn and a respect for ethical research was employed in order to build rapport with the staff. To curtail possible discomfort regarding the term 'race', the terms 'traits' and 'physical features' were used up until the participant introduced the concept of race. The terms 'traits' and 'physical features' in themselves imply a biological understanding of race steeped in phenotype. These terms are used with this in mind, as a manner to open up a dialogue with participants. In addition, given that these professionals specialize in female reproductive health and work with the recipients and donors for the procedures, their insights were both relevant and crucial. Given that doctors have an oath to protect their patient's confidentiality, it was emphasized that individual patient information was not being sought nor required to answer any of the set questions.

In the end, ten interviews of which two were follow-up interviews were conducted with a total of nine participants. These nine participants were all staff working in the field of fertility. A few of these individuals had been through the process of egg donation as intended parents and therefore, had a dual perspective from the position of staff as well as recipient. The purpose of having chosen staff specifically was to gain the perspective of the agents who naturalize the use of racial categories and at times impose it as the obvious means to choose a donor. In addition, because these staff members interact with both egg donors and more importantly, recipients/patients/intended parents on a daily basis, their insights were invaluable as they had a broader view of how intended parents choose egg donors and how they engage with race in this process. Hence, because I interviewed staff from almost all egg donor agencies and fertility clinics in Cape Town, the conclusions drawn from the study had a greater level of reliability and credibility than if the study had focused on a few intended parents. The fertility staff hence, provide perspectives and observations of utmost

importance to the social engagements with race in the fertility industry in Cape Town. Their position as professionals with tertiary education, was of relevance as well because it affected how they viewed race and provided an interesting paradox in which participants understood that race was a socio-historical construct, yet on a daily basis employed it as an essential, biological category.

Data Collection Instruments: To collect the secondary data in the form of literature, the UCT library's Catalogue Aleph, World Cat and electronic databases such as Sociological Abstracts and so forth were employed to obtain relevant readings and academic material for the project. The limitations of this is that I was restricted to the databases and platforms allowed by UCT and did find it difficult to access works outside of these platforms. Primary data was collected as semi-structured open-ended interviews of doctor and agents' observations using both a digital recorder and an apple smart phone. The smart phone was relevant as a back-up in case the recorder malfunctioned. The recordings were transcribed by myself, using a laptop and other desktop computers. Data was kept safe on the devices by password lock.

DATA ANALYSIS

The data analysis was conducted using thematic analysis. Data analysis is often the most complex phase of the research process, but yet receives the least attention in research reports (Nowell et al., 2017: 1). Nowell et al. argue that researchers need to always be clear about what they are doing, why they have chosen to do so and to provide a clear description of the method of analysis (Nowell et al., 2017: 1-2). Thematic analysis is often ambiguously framed within academia, with some scholars claiming that it is not a method of analysis in its own right, but rather it is a process that assists researchers as part of the analysis. Nowell et al. however, disagree with this position and take thematic analysis to be a method of analysis in itself. "Thematic analysis is a qualitative research method that can be widely used across a range of epistemologies and research questions. It is a method for identifying, analyzing, organizing, describing, and reporting themes found within a data set" (Braun and Clarke, 2006 in Nowell et al., 2017: 2). However, in addressing the ambiguities around thematic analysis, Bazeley (2013), argues that there is a tendency to apply descriptive writing to lists of ideas which are supported by very little evidence, using themes as opposed to codes (Bazeley, 2013: 191). But those who support the use thematic analysis point to concerns around fragmenting and decontextualizing the data (Bazeley, 2013: 191). In my analysis, I sought to address concerns from opposing sides of the argument. I employed thematized analysis with the use of codes, understanding the use of the relationship

between code categories in the development of theoretical conceptions and statements (Bazeley, 2013: 190-191). Thematic analysis hence, was utilized in this manner in an attempt to reap the benefits of the analysis, without falling into the trap of its possible downfalls.

The advantage of Thematic analysis lies in its highly flexible approach, which can be modified for the means of many studies, allowing for the provision of detailed, rich yet complex data (Nowell et al., 2017: 2). It is a method that is quickly learned and easily grasped, as well as accessible for researchers starting out in their career. King (2004), as well as Braun and Klarke (2006) argue that the advantage with thematic analysis lies in being able to examine the perspectives of different participants and highlight the similarities and differences, as well as discover unanticipated insights (King, 2004; Braun and Klarke, 2006). The advantages of this method hence, made it ideal for this study. In the theoretical framework I have set out the lens with which I entered the field and what I anticipated. However, given that Assisted Reproductive Technologies is still a relatively new field within South African social science, it was possible that there may have been valid insights and unexpected information on the process of egg donation and race which would arise during the interviews that I was not aware of. Hence, whilst observations regarding race were sought out, the flexibility of thematic analysis, was to allow a space for further discovery. The stages of thematic analysis applied are as follows: “Phase 1 Familiarizing with the data; Phase 2 Generating initial codes; Phase 3 Searching for themes; Phase 4 Reviewing Themes; Phase 5 Defining and Naming Themes; Phase 6 Producing the Report” (Nowell et al., 2017: 4). From the codes the themes were extrapolated which aided in the conceptualizing, explaining and writing of the report. Ultimately, the aim of employing this method was to extrapolate themes that can indicate relevant insights into the egg donation process in Cape Town, South Africa, while also producing research that is both credible and trustworthy.

ETHICS

With all research that involves human participants, there is a need for the researcher to be conscious of ethical issues that may occur. Ultimately, the goal must be to ensure that no harm falls upon the participants or the researcher. Below I have outlined some of the ethical considerations I reflected on for this project.

Participation was voluntary. Participants were not forced to participate in the research project if they did not desire to do so or expressed hesitation. All participants were given a general idea of the scope of the study. They were told that research is being conducted on egg donation in South Africa. The purpose this minute information was given was to ensure that participants understood what was expected of them from the interview and were therefore able to give consent, whilst not divulging too much information about the project so as to affect their answers during the interview. Lewis argues that “a balance...needs to be struck” (2003: 67). Giving too much information that affects answers or deters participants is not ideal, but neither is it ideal to have participants unaware of what the research requires from them (Lewis, 2003: 67). Consent forms were given, which outlined that the participants were able to stop the interview at any point, were able to choose not to answer questions that made them uncomfortable and permission to record was also requested. This was also stated verbally to ensure that the participant was comfortable and was aware that the interview was not binding or forced upon them. Due to the fact that the interviews were being conducted with professionals and agents in the field, a level of education that allows participants to understand their rights in the research process was presumed guaranteed.

In addition to ensuring that consent was obtained properly, the names of the participants, their agencies/clinics and location were omitted to ensure that they are not easily identifiable. In some instances identification may be possible. For instance, when speaking of the largest egg donor programme in South Africa or the way in which the organization categorizes their database of donors, it may be possible to identify the interviewee or their organization if one is familiar with the staff or the database of the organization. Lewis refers to this as “indirect - identification” (Lewis, 2003: 68). It was made clear during the consensual procedure that identification may be a risk, due to the fact that there are only 3 fertility clinics and 4 egg donor agencies in Cape Town. Nevertheless, caution was taken to limit identifying information as far as possible. In addition, participants will also be informed in the case of publication. At all times the aim was to ensure that participants did not feel they are being taken advantage of or violated. Additionally, to ensure their confidence was protected, the recordings were kept on a password controlled device to ensure that a third party outside the project was not able to access the data.

Due to the nature of the research's focus on race and the aim to deconstruct how recipients make choices for donors based on race, it was possible that participants would find the questions or probes upsetting or take offense. Some of the people who work in the field of fertility and reproductive technologies have experienced issues with fertility themselves and therefore, have a personal link to the experience as a professional and as a patient. Race is a very sensitive topic in South Africa given its apartheid history. Whilst I anticipated that there would be no issue, it was necessary to think and be prepared for such circumstances. In the event that a participant was becoming visibly upset I decided I would not persist on having them answer. In instances during the interviews where participants appeared to be uncomfortable, I reminded them that my questions came from a place of wanting to understand and that it was not a critique on them or their work. In other instances, I moved to a different question, making a note to reframe the question and ask at a later stage in the interview. Discomfort was a particularly difficult phenomenon to navigate as it was dependent on me reading the non-verbal communication of the participants. The aim throughout the interview process was first and foremost to avoid harm to the participant, whilst also understanding and maintaining my role as researcher.

In addition, I acknowledged that I am in no capacity to give advice as this would be counselling and decided that if it seemed necessary (due to the psychological distress that comes with infertility) would suggest a relevant counselling organization to the participant. Lewis makes it clear that divulging advice begins to cross the boundary beyond the role of researcher (Lewis, 2003: 69). If participants had any concerns about the research, I referred them to my supervisor, associate Professor Amrita Pande. Whilst preparation to conduct research ethically was taken, the nature of qualitative research and its fluidity is such that ethical dilemmas may emerge in the field that were not anticipated (Birch et al., 2012: 1). Birch et al. argue that 'thinking ethically' throughout the research process and having a contextual, situational and practice-based approach is becoming ever more necessary (Birch et al., 2012: 1). This contextual and situational approach was relevant during instances of discomfort on the part of the participants. Whilst I was prepared for participants to be upset, discomfort was a terrain I had to navigate as the interviews happened. Particularly because participants did not verbalize their discomfort and I had to interpret their non-verbal actions. The relevance of being aware of ethics throughout the project hence, was of utmost importance.

PROLOGUE

I'm sitting in the reception area of one of Cape Town's fertility clinics. There are numerous patients in the reception area with me, many appearing to be 35 years of age and upwards. I see two young women who I assume may be egg donors. As I sit and wait, a family of three adults walks in with a new born baby wrapped in a yellow blanket. The baby is fussing and cooing. I look up and I see many of the middle aged couples and women looking towards the family. Many of them smile and have what I perceive to be a glimmer of hope in their eyes. Prior to the entrance of the family with the baby, these patients looked anxious and concerned. The baby brought with it a warming feeling to the atmosphere and whilst I am very critical of healthcare and the stratifications that exist in accessing it, I couldn't help but smile.

The process of egg donation is a very complex one that involves many steps and numerous people from varying backgrounds. Before I delve into the discoveries of my research, I feel it is necessary to outline how the process works according to the staff I interviewed. Generally, there is a couple, a man and a woman that fell in love and got married (whilst this does not apply to all patients such as their homosexual patients, it makes up the predominant demographics of their patients). Whilst married this couple attempts to have a child. After some time when realizing that they are not conceiving they visit the doctor/gynaecologist/urologist. If infertility lies with the man, a semen analysis is undertaken as well as additional tests, if needed, to determine the correct course of treatment. In the event that these treatments are not successful, the fertility specialist then recommends using a sperm donor. However, scholarship indicates that men often do not admit to infertility and instead blame it on the woman (Dyer et al., 2004: 961-962). If infertility lies within the woman, they are then given medication to try and stimulate their ovaries so that conception becomes easier. When this does not work they are then referred to a fertility clinic that specializes in this. They have tests done and from here they often try Intra-Uterine Insemination (IUI) and In-Vitro Fertilization (IVF) using their own biological tissue. The IUI involves having the husband's sperm being placed directly inside the woman's womb whilst she is ovulating to try conception, the latter process, involves fertilizing the egg with sperm in a petri dish first and then inserting the embryo back inside the woman's womb. Whilst causes for infertility vary greatly, often it is due to early menopause or egg degeneration that women then have to consider using a donor's eggs. This is the part that is painful for patients, because it is the part where they must reconceptualise what it will mean for the family they had been dreaming of, to introduce a donor's biology. They then visit the egg donor agencies to find an egg donor they find desirable. The donor agency then laisses with the clinic to organize the IVF process, because egg donation in South Africa is anonymous.

The two women's cycles are synchronized, the eggs are extracted from the donor and after fertilizing them to become embryos are then inserted into the intended mother/patient. This thesis will examine the egg donation process. The purpose for choosing to focus on egg donation and not sperm donation is due to the phenomenon of many men not presenting for treatment and being reluctant to admit infertility due to the feelings of emasculation that come with it (Dyer et al., 2004: 966). Hence, this thesis focused on the process of egg donation, specifically the part where the recipients choose a donor, with the aim of understanding what they look for and why? What role does race play within this process?

Race has been and continues to be the identity category that does not escape our postmodern lives. Despite 24 years since the advent of our new dispensation in South Africa and the dismantling of apartheid, one need only look at the media and the news to realize that racial tensions are rife and amongst us. Yet, whilst we understand that race is a relevant tool in the redressing of past inequalities, egg donation and ARTs at large seem to perpetuate the use of race within the egg donation process. Donors are categorized by race and race is the first identifying category used online in the search for a donor. Race is the key visual marker of identity used in categorizing people after gender and I suppose it must come as no surprise given that the skin is the largest organ of the body. But what is it about the emphasis on this organ's pigment that is so crucial in the process of egg donation and making a family? Are these not perhaps creating a space for race-matching? The race matching which was pinnacle to projects of Eugenics in the 18Th and 19th centuries? To answer these questions and to reflect on what they mean for both social science scholarship on egg donation and race is now outlined in this thesis.

CHAPTER ONE: THE CENTRALITY OF RACE IN THE EGG DONOR SELECTION PROCESS

"Well, I think the problem is um, race is obviously an artificial construct, so it is different to your ethnic background. Your ethnic background is where you have grown up and what has influenced you. In your community or whatever…so I think your ethnic background is what you have absorbed from around you, you know your parents, your friends, your social circumstances of whatever. That will make your ethnic background. I think racial profiling is different because certainly in South Africa it was more of a legal, arbitrary definition that people made. That's why it became so problematic because they couldn't fit some people in the boxes, in the terms of what the heck race is this person (Laughs). And they tried all these ridiculous ways of trying to figure it out." (Laughs) (Participant 9, Interview 10)

Despite the human genome project's discoveries of the lack of hereditary significance with race, race continues to be the central marker of identity in the process of selecting an egg donor. Whilst the social sciences understand race to be a social construct with no scientific validity, ARTs have allowed for a resurgence of the use of race in the field of science (Roberts, 2011). Racial categories are used in the process of selecting an egg donor, it is the first marker of identity after gender that is used. Yet, history has shown us that not only is race artificial, there are also many people who do not fit into the given categories. I often find myself wondering that if the use of racial categories is truly about finding a donor that resembles the intended parent, why not use a spectrum of skin colour pigments? What is it about race that this marker of identity is so central in choosing someone of our likeness? The interesting matter at hand is with the way in which donor agents naturalize race and point to its "obviousness" as a necessary identity category in the process of selecting a donor. The implication of this ultimately, being a replication of ideas surrounding the myth of racial purity. A black woman should want a black egg donor, and a white woman should want a white egg donor, and unless recipients express a different desire, donor agents will often implement or assume that a racial-match is the desired and natural choice. Russell makes the argument that this naturalization of race is so eminent that the race of the child does not constitute a choice (Russell, 2015: 605). Similarly to Russell, my study indicated that the naturalization of race-matching was prevalent amongst egg donor agencies and their staff.

1.1 THE NATURALIZATION OF RACE IN THE EGG DONOR PROCESS

1.1.1 THE RACIAL CATEGORIES

"That thirteen page document for each donor. So you'll get your, um, different races which will be Indian, Black, Coloured and White. I think we only ever had one Asian. Um…but those are the ones, the four races" (Participant 1, Interview 1).

"Right, so the basic categories are race, so um, we have African, European which would be Caucasian or White, um, African, European, and by African we mean black…we've had to use words that we don't really use in South Africa because…or words that everybody would understand. So we don't call white people European in South Africa. Unless you're trying to be awfully politically correct and make everyone uncomfortable (Laughs), by referring to them as a European guy…Yah so, African, European, Coloured. We say 'Cape Coloured', because we used to say 'Coloured' and people would get confused with that as well. Asian, um…Indian. So there's a difference for us between Asian and Indian, and um, mixed origin, where a donor is bi-racial or has a mix, but a very clear one. So not necessarily Cape Coloured, but like one of the grandparents is European and the other one is Chinese and another is African. That would be like mixed race. So those are the basic…" (Participant 2, Interview 2).

P: So it's Caucasian, Black and what we call mixed race or Coloured, because a lot of internationals don't know coloured. They know mixed race. Yah, and then Asian.

R: Okay, with with the Asian…

P: Oh, sorry! And Indian… (Participant 3, Interview 3).

Above participant 1, 2 and 3 point to the use of racial categories both by them as donor agents, as well as on their website. There are five racial categories that are employed, similar to the ones used during the apartheid era. White/Caucasian, African/Black, Cape Coloured/Coloured/Mixed Race, Asian and Indian. At one of the agencies they distinguish between Cape Coloured and Mixed Race. Nevertheless, all of the donor agencies consulted for this study pointed out the use of racial categories in the process of identifying an egg donor. Already, there are discrepancies that may be identified in these categories. For example, the synonymous use of 'African' and 'Black', implying that Caucasian or Asian South African people are not African. The fluidity of 'mixed race' and coloured, and the reductionist category of 'Asian'. The concern is that during the apartheid era, the government of the time simply placed very heterogeneous people into reductionist categories without much meaning, such as 'coloured'. There are Coloured people who originate from Malaysia and make up the 'Cape Malay', there are Coloured people who are descendants of the Khoi

and San people, but were placed in the category Coloured, instead of Black due to the light brown pigment of their skin. They were people of African, Asian and mixed descent and due to the colour of their skin were labelled 'off-white', 'half-castes', 'bastards' and then came to make up the identity group, Coloured (Adhikari, 2013: xi). The case with racial categories is not only in its perpetuation of apartheid categories which were state-given and reductionist in nature, but also in the fact that these categories are not clear cut and there are many people who can "pass" for another race they do not identify with. Whilst these categories are important in their use of redressing social injustices of the past, ART employs race as though it is a natural and given way of identifying people, despite its reductionist nature. It is employed as though it is the ultimate determinant of what makes a family (Quiroga, 2007; Russell, 2015). This was made evident in my interviews, where donor agents repeatedly pointed to the 'obviousness' of race as a means of identifying donors and recipients.

1.1.2 THE 'OBVIOUSNESS' OF RACE

"It sometimes, um, sometimes when the recipient is white for example and she chooses a black donor and the husbands black, it is a bit confusing because people… you would look for that um, if she were to have a child with him the child would be multi-racial. There would be a mix, so for us its sometimes confusing that she would choose a black donor, because then it will be…a black child…" (Participant 1, Interview 1).

Because most people choose their own race, um…you know there is no, I've never asked anyone why they choose black if you're a black recipient. I've never asked. I've never felt a reason to ask why you yourself are choosing a black donor if you are black. Because it feels obvious to me (Participant 2, Interview 2).

"Mostly by race because uhm, because for obvious reasons. Mostly by race and then sort of, more sort, work our way down from there. For example if you called us and you were looking for a donor, there's no point in us sending you all our white donors…unless that's what you want…Yah sure. Um. I think, like so, if you look at sort of. If you were going to have your own natural child, you think of, like sort of what will he or she look like. So I think, that's sort of where I say, um, sort of, um, this is my thinking. If I was interviewing you as a recipient, I would think that you would obviously be looking for a black donor, sort of, if your husband was white. Possibly a coloured donor, so you have a happy medium" (Participant 5, Interview 6).

R: Okay, do you know if racial categories are used?

P: I would assume so. Obviously yes. Because if a patient is looking for a black donor, a white donor, an Indian donor, they would need to know where to start. (Participant 6, Interview 4).

Above excerpts from conducted interviews indicate that donor agents and fertility staff in general, determine that race is the natural and 'obvious' means of identifying an egg donor. Participant 1 points out that in instances where recipients choose an egg donor from a different race they find it "confusing", as though the natural and 'obvious' choice is to choose a donor who is of the same race. Hence, participant 2 states that she never feels the need to question when recipients choose to racially match because it feels 'obvious' to her. Participant 5 expressed similar sentiments and went on to say that if I was the recipient who had approached her she would automatically assume that I am looking for a black donor, given that I am black in appearance and identify as Black. Whilst there is no problem with recipients wishing to select a donor who is of the same racial category, the phenomenon to deconstruct is the way in which donor agents and ARTs at large impose race and perpetuate it as a naturalized and 'obvious' means of identification, despite the fact that race is in fact a reductionist social construct with no genetic validity.

As the gynaecologist I interviewed points out, race was problematic because there were instances where the government could not place racially ambiguous people into a clear-cut category. Race was about a system of oppression that placed human beings in a hierarchy based upon their appearance (Winant, 2000; Adhikari, 2013). Despite this understanding of race as a social construction by fertility staff, there is also an essentialist understanding of race at the same time, presenting a paradox in which race is a social construction yet an integral part of identification of someone in one's likeness at the concurrently. The interesting part is that race is not an automatic qualifier for how a person appears, yet *the look* understanding and process of racialization is the one that donor agents employ (Erasmus, 2017: XXII). There are many people who identify as Black, but appear Coloured. There are people who identify as Coloured, but are able to pass as white. Which hence, begs the question of the validity and necessity of race as a means of identifying a person in one's likeness. Aside from the ambiguity of race and its social constructiveness, the other matter is that donor agents take it to be natural and expected for recipients to racially–match when choosing a donor. Hence, if a recipient desires otherwise, they have to state so, and in some cases explain their choice. The problematic nature of this being a resuscitation of eugenic ideas around the myth of racial purity, in which white people were to reproduce with Whites and black people were to reproduce with Blacks, so as to maintain a pure and superior race (Whiteness) (Ikemoto, 2007). These dynamics continue to play themselves out in these Reproductive Technologies. Donor agents may hold naturalized views about race-matching

in the process of selecting an egg donor but it is not their sole desire. Even recipients who do not seek assistance in selecting a donor tend to racially-match when selecting a donor. This happens for numerous reasons, but the first is said to be a search for resemblance.

1.2 RACE-MATCHING AT THE CENTRE OF DESIRABILITY

1.2.1 RESEMBLANCE AS THE AIM

"Most of them and they, what's important to them is that the donor must at least look similar to the recipient. So when they come they say, 'I want a donor who looks as much like me as possible, so if you can find someone that has, as much as you can find of me, then I'd be really happy.' Because you can never really find a perfect, perfect match, but there will be someone that's close" (Participant 1, Interview 1).

"Uh, the physical features. Um, yah, so the physical features, eye colour, hair colour, um, something familiar in the look. So she might look like my sister or my little brother when they were babies in the childhood photos. Although that doesn't happen often to find someone who looks like someone someone someone, in your family. That's magic, it's magical when that happens. Um, so there's that" (Participant 2, Interview 2).

"And then 99% of the time, the recipient will choose a donor that looks like the mom to be. If she's tall, blonde and blue eyed, she'll choose a tall, blonde and blue eyed donor. If she's a short, dark African lady, she will choose a short, dark African lady, so that hopefully the baby looks a little bit like the mom…Um, so yah…So people choose, recipients choose donors for all sorts of reasons, but the most important aspect full stop is the physical resemblance to the mom. Now a lot of people who don't know will say, 'Oh, designer baby!' You know they try to do a designer baby, it's not true. They want someone like them. They don't want…if she's short and dark, she's not going to choose a tall and blonde donor… (Participant 3, Interview 3).

"I've had a patient in the past who didn't even want to know who the donor was, we must just pick a donor for her that is young, healthy, has had previous successful donations, um and that's how she wants to move forward. Those are few and far between though! Laughs. The most common thing we get asked is, 'Do you think she's a good physical resemblance?' And it's very hard to say no. (Laughs). It's very hard to say 'no' to questions like that, but I do try to be as honest as possible" (Participant 6, Interview 4).

"So, usually they want somebody whose physical characteristics match theirs and they also, for a lot of them at the top of their wish list they would like somebody who is well educated

and um, attractive. Also on their wish list, is somebody, it also sometimes counts in a donors favour if she has previously donated successfully. But everybody has got to start somewhere. But yah, I would say the main thing is that, somebody whose physical characteristics match theirs" (Participant 7, Interview 7).

"I think most patients start with the physical characteristics, trying to match with the mother. They often start like that. They will look at the donor's physical characteristics, and then they often narrow it down to a certain number of donors. They might have 5 or 6 donors that are physically similar to the mother, and then they often look at other characteristics" (Participant 9, Interview 10).

Above all fertility staff interviewed indicated in the conducted interviews that the most important aspect in searching for an egg donor was to find someone who resembled the mother. Hence, physical characteristics are often the first criteria used by recipients and donor agents to narrow down the search for a donor. Participant 3 states that the most important aspect is always the physical resemblance to the intended mother. She points out that many who criticize the process of egg donation will often state that 'designer babies' are being made (Suter, 2007). Whilst she states that it is not true, it is about finding a donor who resembles the mother. In addition, participant 6 points to the fact that she has had patients who do not care about the physical characteristics of the donor, but simply want to have a healthy baby. These recipients she states however, are not common and are far between. Maintaining that most recipients will often desire a donor that has some physical resemblance to the intended mother. Becker, Butler and Nachtigall write about this phenomenon of resemblance in their work (2005). Pointing out that often people search for resemblance between parents and their children. Hence, with egg donation recipients will seek a donor who is physically similar to them, in the hopes that the child will look somewhat like they do when they are born. The desire for resemblance stemming from a hope that the child will pass as the biological child of the social family and hence, be accepted as such (Quiroga, 2007: 150; Becker, Butler and Nachtigall, 2005). This is further done through the use of photographs. In South Africa, egg donation is anonymous. As a result, intended parents are only able to access pictures of the donor up to the age of ten, to protect the donor's anonymity. However, due to the fact that the egg donor agents and doctors can see the adult photo of both the recipient/intended parent and donor, recipients will at times ask donor agents to ensure that the final donor chosen is the closest in resemblance.

"Yah, so if there's a recipient that comes through, that's one of the first things that we ask if they don't say, but if they send photos, you can look from the photos what they are looking for…So we, that's where we do the two photos together because they're not allowed to see the donor…So we take their photo and we take the donors photo all together and then we're

able to tell them, your nose is exactly the same, her eyes are more almond shaped than yours, the jaw line is more square than yours. So those are the things that we look at" (Participant 1, Interview 1).

"So what they say is, can they send me a photo of themselves and then I will match. Then I tell them, go online and give me a shortlist of your top five that you like and I will tell you of those five, which most closely physically resembles you and I'll give them some advice on that" (Participant 3, Interview 3).

"So I look at the adult photo of the intended parent and then I look I look at the adult photos from donors in our database, because it's anonymous, so they can't see them. And I help them try find a donor, everyone is looking for something different" (Participant 4, Interview 6).

"The only thing that they sometimes ask us to ourselves, because they can't see the adult picture, sometimes they've got two donors in mind, and they'll ask us, 'you can see the adult, tell which one looks more like me" (Participant 9, Interview 9).

"It's kind of half/half in terms of, they want, what they call resemblance. You'll get some recipients where that is their main focus. Um, often we'll get recipients sending us their picture and wanting to know if the donor looks like them. Then the other half aren't too bothered about physical traits, they want someone who's intelligent and educated" (Participant 6, Interview 4).

In the above excerpts, Participants 1, 3, 4 and 9, all point to the use of photographs at the request of the recipient, to allow them (the fertility staff) to see which donor most closely resembles the recipient. Participant 6, points to an even split in desirability between resemblance and intelligence, with intelligence often being measured as being within or having completed a tertiary qualification. Nevertheless, many recipients often desire resemblance between themselves and the donor. However, whilst resemblance is the ultimate aim of the majority of recipients when choosing an egg donor, the starting point in selecting a donor who resembles them always starts with race and a process of racialization that employs *the look* as its epistemology. Race hence, remains the significant marker of identity in the egg donation process, despite its fluidity, constructive nature and lack of hereditary significance.

1.2.2 FROM THE GENERAL TO THE SPECIFIC: MATCHES IN RACE THEN PHYSICAL FEATURES

"Uh, basically eye colour and hair colour. (Laughs). That's the most…eye colour and hair colour…Um, if it's a black recipient, they will specify, which will be different though compared to the others. And the coloured as well, the coloured recipients, they would specify in the beginning they're looking for complexion. So that there's something that's big for them. So a lot of the black recipients and the coloured recipients say, 'We're looking for a donor that's light.' Um, and then we have…on the odd occasion where they'll say we want a dark complexion, they must be dark in complexion" (Participant 1, Interview 1).

"There's the physical stuff, the height, the body shape, the skin tone. The skin tone is more important in African patients because um, if you, like I'm light skin, my father is light skin, my mom is dark, so that would not matter to me. You know, but if you're a family of light skinned black people and then your baby's dark that might be a problem…For us we have the largest African donor database. Um, however, there is more of a demand, a greater demand for European and white donors" (Participant 2, Interview 2).

"Whether the donor is Asian or white, or any other racial group, it would be deemed irrelevant because you can deal with it later. And someone isn't going to point out that necessarily, 'Oh, you look so different to the rest of your family, what's going on?' because of your skin tone if you are a white family. But um, then, in terms of what they find important I would say is the same thing other recipients find important um, whether or not the donor looks like them…I don't know. I'm going backwards and forwards on this because on the other hand a black recipient if they are looking at a donor and she is light in complexion and the donor we show them is dark in complexion, they immediately move on. So, complexion is important but I can't say if it's the most important thing" (Participant 2, Interview 5).

"We have very, very few people who take a donor from another race, less than 1% of the time does that happen. The only time it happens is with an Indian couple, who might choose a dark skinned Caucasian donor. But we've never had a white recipient choose a black donor or a black recipient choose a white donor, because they want the baby to look like them. For Indian, I think for some Indian couples, if they're quite pale, they can choose a Caucasian donor that's quite fair. But otherwise they don't go. So they will choose a donor, they type in the search criteria, show me all the donors who are tall, black and um, and whatever frame, Cape Town… Another interesting thing is that, with a lot of African recipients. We get a lot of African recipients from Angola, and Zimbabwe and those places. They choose donors upon skin tone, complexion. Very important to them. So if they dark,

they want a dark donor. If they're fair, they want a fair donor. They're less concerned about academic qualifications or musical or sporty. But skin complexion is very important to them" (Participant 3, Interview 3).

"We have had recipients that say, 'uh, can you please tell me their skin tone?' Even with our white donors, the recipients go, 'She looks a bit olive, can you tell me what her skin tone is because all the people in my family are quite pale.' Or we'll have coloured recipients who will choose a very dark white person and black recipients who will choose a darker-skinned coloured donor" (Participant 4, Interview 6).

"So what we decided was… so we looked for that, and we looked for somebody who had green or blue eyes, my eyes are green and a sort of similar colouring and…and then second time around we decided we actually wanted someone who had had previous success" (Participant 8, Interview 9).

The above excerpts show that while resemblance is the desired end result in choosing an egg donor, race and then furthermore skin tone (particularly in the case of Coloured and Black patients) is used as a tool to facilitate selecting this donor. Participant 1, 2 and 3 all point to the ways in which differently raced recipients engage with race in the selecting of an egg donor. They point to the fact that for white recipients they often look at the phenotypical features of hair colour and eye colour in their search for a donor. Donor agents note that due to the variation in hair and eye colour that white recipients have, they then also tend to focus on other softer traits such as academics, or musical and sporting talent. Whilst the recipients of colour, due to the fact that many people of colour in South Africa generally have dark hair and dark eyes, they take skin tone to be their primary focus. Participant 2 indicated in her follow up interview that whilst she was not sure if skin tone was the most important aspect for recipients of colour in choosing a donor, she did note that if a dark coloured recipient was shown to a couple that were light in complexion, they would immediately move on. These choices being reminiscent of colourism and the preference for light skin (Walther, 2014: 521). Among recipients of colour, beyond race, there is a distinct effort to match the skin tones of the recipient and the donor as well. Whilst participants 1, 2 and 3 stated that white recipients are not always too concerned with tone, Participant 4 pointed out that amongst white recipients she has encountered they will take note of the difference in skin tone between what would be considered a pale white person, and an olive toned white person. Hence, even within these racial categories there are variations of skin tone that recipients will at times aim to match, beyond the racial group.

The effort to try as far as possible to firstly, match the race and then secondly, match the skin tone indicates the perceived importance and validation of family that comes from being

the same colour (Harrison, 2013). The former phenomenon of race-matching is one that many scholars on ART and race point to in their work (Ikemoto, 1995; Krolokke, 2014; Quiroga, 2007; Russell, 2015).). The importance placed on racial matching is prevalent, with scholar Russell making the argument that until recently the largest sperm bank in the United States would send semen in colour coded vials to allay fears of racial mis-match (Russell, 2015: 605-606). In addition, there is often a strong reaction that people have when a recipient chooses ova from a donor who is not of a same race (Ikemoto, 1995: 1016; Quiroga, 2007; 1015-1016). This study found that race-matching is also prevalent in Cape Town with Participant 7 pointing to this when asked how recipients engage with race. She stated that generally black recipients choose black donors and white recipients choose white donors. It is the mixed race couples that may select either. Hence, mixed race recipients have more leeway to experiment racially with their choice. But between the imposed binary of Black and White, it remains expected and practiced that Black recipients will choose a Black donor and White recipients will choose a White donor. This dynamic which is created in the process of selecting an egg donor mimics the eugenic practices and ideologies of the myth of racial purity. The latter phenomenon of further matching skin tone, is indicative of a desire to further legitimize hegemonic notions of the family through specifically colour-matching. Even within the same race there are various shades of complexion. This is pointed out by Participant 2 who says, “You know, but if you’re a family of light skinned black people and then your baby’s dark that might be a problem”. Not only is the desire to match colour relevant for further legitimization but in addition, there is also the need to note that skin colour creates what is termed, ‘epidermic capital’ in which there are privileges that come with being of a lighter complexion (Walther, 2014: 521). Perhaps explaining what Participant 2 further notes, “a black recipient if they are looking at a donor and she [the recipient] is light in complexion and the donor we show them is dark in complexion, they immediately move on”. Hence, whilst race and skin tone/complexion are two classifications that at times overlap and intersect (Deomampo, 2016: 307), within the South African context, recipients distinguish between the two, using race first, and then, particularly in the case of patients of colour, skin tone to ensure the closest possible match of skin pigmentation. The aim being two-fold. Firstly, to ensure legitimacy for the family structure and in particular the social parent and secondly, specifically for fairer patients of colour, to ensure the epidermic capital that comes with lighter complexions is passed onto the child.

1.3 DESIRES TO CONCEAL

1.3.1 STIGMA, CULTURE AND RELIGION

What became very evident in my research was that not only do recipients wish to racially match as a method of seeking resemblance, but that this strong affinity for resemblance derives from the desire to conceal the use of reproductive technologies and in particular, the body tissue of another person. Donor agents pointed to the cultural stigma surrounding infertility as well as the desire to avoid marginalization within religious communities.

"I know in particular in African communities, because we are more conservative, um, the likelihood of you, of you being okay with people knowing is less. Um, so I think that, that is, does play a role, I think…because of fear." (Participant 2, Interview 2).

"I've got no stats to back me up, but my feel is that most African recipients will not disclose to their children or to anyone else that they have received a donor egg. Whereas half of the Caucasian recipients will disclose…I think that's got a lot to do with how fertility is seen as part of your social standing within the community from the different…from the different races and ethnicities" (Participant 3, Interview 3).

"And then there is a huge stigma around infertility, especially in the African community. I think I did mention to you last time 90% of my black African patients will not disclose. Whereas, 60% of my Caucasian patients will. So it's also very cultural" (Participant 3, Interview 3).

"But yah, it probably is like with someone I interviewed the other day, that I met with, she's um, a black woman, Xhosa speaking and she said she definitely wouldn't tell her parents, her family, because yah, for those reasons exactly… Like, the one I was telling you about whose in my support group, she's a white woman, but from an Afrikaans background and I think, she felt that her parents wouldn't approve of that. I don't know…I think culture, family background, conservatism and things like that probably plays a lot…a bit of a role" (Participant 8, Interview 9).

The above excerpts from participants indicate that there is a shame and a stigma that still hinders recipients from wishing to disclose due to cultural reasons. The donor agents make the distinction between Caucasian recipients and Black recipients in terms of disclosure rates. Participant 3 states that she mainly observes these differences between her Black and White clients. They state that roughly 40% of White clients will opt not to disclose,

whereas 90% of Black patients will not disclose.[2] She attributes this to the perception of fertility within Black families. Indeed, within numerous African cultures children are seen as a blessing, and a woman who cannot have children to carry on the family name is often shunned (Dyer et al., 2004: 964). Participant 8 states that she does have a woman from her support group who opted not to tell her Afrikaans parents because they are very conservative. Hence, whilst majority of Black patients do not disclose the use of egg donation due to cultural factors, there are white patients as well who come from conservative families where the use of egg donation is not supported. The phenomenon of there being a greater stigma towards infertility amongst Black patients indicates a racialized dynamic to the stigma associated with infertility. This stigma is not only racialized but is also globally geographical. The consequences of infertility and the stigma associated with it is higher in the Global South than in the Global North (Tabong and Adongo, 2013: 1). These racialized and global dynamics to the stigma of infertility are further reinforced by a false perception that the Global South does not and cannot have an infertility problem. Due to dominant discourse which perceives people of colour, in particular in the Global South, as being hyperfertile (Pilcher, 2006: 975). Leading to great suffering for couples, especially women living in these contexts where children are highly valued given the gendered dynamics that underpins this stigma as well.

In addition to being racialized and globalized, there is also a gendered aspect to the stigma of infertility. The burden of infertility and the blame is often, if not always, placed upon the woman, leading to greater consequences for the woman. Tabong and Adongo discuss examples of these consequences, finding that infertility is considered a major reason for divorce and marital instability in Africa and that women who suffer from infertility often fear divorce, abandonment and polygamy (Tabong and Adongo, 2013: 2). Infertility hence, can be a source of great shame for families in contexts where children are highly valued. The desire to conceal the use of an egg donors hence, is high because of the desire to conceal the fact that the female is infertile. Recipients find greater comfort in searching for resemblance to hide their struggles with infertility from others due to the marginalization and oppression that stems from it.

In addition to cultural and social contexts where infertility is stigmatized there is also among some fear of being ostracized/marginalized by religious communities that underpins concealing the use of donor tissue. The desire to conceal hence for these couples, is not solely based in the stigma attached to infertility, but the doctrines of their faith which do not

[2] What is interesting is that despite many more white patients choosing to disclose, there is still often a desire to racially–match. Indicating that whilst desires to conceal are a part of the motivations for racial-matching, there are still other prevalent factors leading to this phenomenon.

allow for the use of donor tissue. They pursue a racial-match and a donor who resembles the intended mother to conceal their use of donor tissue as it opposes their faith and want to avoid marginalization from their religious communities.

"In fact in some…you know Muslim people are not allowed to do egg donation. I don't know if you know that. It's against their religion because they see it as I think, as far as I understand, they see it as adultery, so they won't tell anyone for fear of being kicked out of their community. So it is complex but there certainly is a stigma and a shame involved" (Participant 3, Interview 3).

"Then for some couples its religious reasons. Jewish couples and they've gone outside of their faith and used an egg donor, may not want to tell anyone. So um, other people just think, 'Uh, it's nobody's damn business!' [Laughs]" (Participant 4, Interview 6).

"It could be, but there's definitely some whose religion does not allow fertility treatment but they have gone ahead and done it anyway" (Participant 7, Interview 7).

Participants 3, 4 and 7 hence all point to the desire to conceal because of religious doctrine. For instance, participant 3 states that in Islam the use of egg donation is controversial because the use of the donor tissue is seen as adultery. As a result, these recipients opt not to disclose after having gone against their faith, hence, resemblance becomes of the utmost importance to them. Marcia Inhorn finds in her scholarship on infertility in Middle Eastern Countries that within Sunni Islam, third-party gamete donation is banned (Inhorn, 2011). The Sunni religious decree allows for the use of Assisted Reproductive Technologies using the egg of the wife and the sperm of the husband. However, due to marriage being a contract between the wife and the husband, no third party can participate in sex or the process of procreation, thereby disallowing egg donation (Inhorn, 2011: 94). Hence, the desire to racially match derives from a desire to conceal the use of donor eggs. This is due to cultural factors as well as the stigma that accompanies infertility and finally religious reasons. There is a globally raced and gendered dimension to the stigma of infertility, which aids in possibly explaining the desires to conceal amongst female patients of colour. In addition, conservativism amongst certain cultures also influences the desire to conceal. Finally, religious reasons, such as the banning of third-party conception in Sunni Islam, also explains the desire to conceal through racial-matching. What is of interest however, is even couples who choose to disclose, still often opt to racially-match. Again, pointing to the role of race in the perceived legitimization of hegemonic notions of the family.

1.3.2 FEAR OF FAMILIAL REJECTION

"I think…it starts with mourning the loss of your own DNA. And then moving onto the fact of 'okay, well if I'm going to use an egg donor, I'd like them to be as physically…no that's the wrong word…to be as um, alike, in physical characteristics to themselves. Yah." (Participant 6, Interview 4).

But above and beyond the stigma and cultural beliefs, with the widespread use of reproductive technologies by celebrities and many women as they grow older, the stigma and shame of using these technologies is diminishing (Almendrala, 2017), yet the desire to conceal remains prevalent due to what I term a 'fear of the family'. Families are social units of utmost importance and centrality in our lives. They are the place we learn to bond and are socialized in the ways of our surroundings. It is not far off therefore, to say that families are generally the most important people in the lives of a person (Macionis and Plummer, 2008: 583). General expectations about qualities family must afford us are such as love and acceptance. Yet for the longest time the family has been conceptualized with genetics and biology in mind. The quote above from participant 6 indicates this. The common discourse about an ideal family lies in a genetic link. These ideas are greatly pervasive, such that upon discovery that a female may not use their own tissue in the reproduction of their child, there is a grieving process of intense sadness that ensues. Families also place the notion of a genetic link in their conceptualization of family, as a result recipients seek to conceal their use of ARTs, in particular egg donation, out of a fear of their children not being as loved and accepted (Becker, Butler and Nachtigall, 2005). Whilst some participants pointed to shame and stigma, religious and cultural factors as facilitating a desire to conceal the use of egg donation, all participants made the point that the desire to conceal largely derives from a fear *of lack of acceptance and adequate love for the child from other family members.*

"They want their family and friends to believe that it's their child. So this is why they need them to look as much like them as possible" (Participant 1, Interview 1).

"What I definitely agree with is that a lot of recipients are very keen to ensure that their child will fit in the family. That people won't like, 'where did that kid come from' or even innocently make…like not even dreaming about any medical intervention, 'Oh, so strange, your kid doesn't look like anyone in your family.'"(Participant 2, Interview 2).

"The main reason is that they don't want friends or family, maybe 40%, they don't want friends or family to reject the child. So I have many women who say, 'I'm worried that my mother will love my child less, than my sister's child because that is her biological child.' So that's the one, worry that the child will be neglected. The other concern they have is that the

child will hold it against them and say, 'you're not my real mom.' Something like that" (Participant 3, Interview 3).

"Some come from big families and they assume that the family is not going to accept the child. They um, yah that the other grandchildren, they never want the grandmother to go, 'that's not really my grandkid.' So they've got this perception. It might not happen, but they're stuck with this, 'they're gonna treat the child differently because it's not biologically mine'" (Participant 4, Interview 4).

"Um, and then, I think linked to that is…um…I don't know really…misconceptions…uh, I suppose that…like egg donation is…means you're not the child's mother, maybe, people think that. I mean my mom actually said to me when I was pregnant, she made some comment about the mother. And I was like, 'I'm the mother, that's the donor'…it's interesting, does she have a better connection with him than with my twins? I think she does actually… she knows it's their blood that's running in him so she prefers him, you know? " (Participant 8, Interview 9).

Participants indicate that whilst there are numerous factors that affect the desire for resemblance in order to conceal the use of donor eggs, the primary reason is the fear about the child not being accepted and loved adequately by family, due to the missing genetic link. What the interviews have revealed is that resemblance is the main aim of recipients and the resemblance derives from a desire to legitimate the family and a desire to conceal. As participant 2 points out, innocently and unconsciously people automatically search for resemblance between the child and the parent, illustrating the argument made by Becker, Butler and Nachtigall about resemblance talk. Whilst there are numerous reasons couples choose not to disclose the use of donor conception, the greatest factor appears to be a fear of rejection from the family and hence, the use of donor conception is hidden to protect the child. This is partially embedded in the normative kinship model which equates family with a "blood" or genetic relationship. These genetic links are reinforced in everyday life by phenomenon such as resemblance talks (Becker, Butler and Nachtigall, 2005). Genetics and parenthood are inextricably linked, so strongly that the biological parent is seen as the 'real' parent and the parent that raises the child, is given an alternate name such as 'social parent' or 'adoptive parent', hence, giving the impression that they are always second to the biological parent (Hargreaves, 2006: 269). Participant 8 points to this in the above excerpt, noting that her mother has a greater bond with her nephew than with her twins possibly due to the lack of a genetic link and participant 3 alludes to this, noting that recipients fear that the child will reject them as the 'real' mother when they are older. Illustrating hence, a normative conceptualization of motherhood lying in biology, as opposed to the social process of raising a child. MacCallum and Golombok (2007) find similar arguments in their

study of disclosure decisions among mothers of donor conceived children. They discovered that mothers who opted not to disclose firstly, did not do so to protect their child. There was a fear that with knowledge of the lack of a genetic link the family would treat the child differently. Secondly, they chose not to disclose due to concerns about disapproval (Shehab et al., 2008: 182), particularly from grandparents who are said to be 'of a different generation'. Thirdly, there were other reasons such as opting not to disclose the use of donor sperm to keep the husband's infertility a secret (MacCallum and Golombok, 2007: 2892). Similar sentiments are expressed by participants of this study in excerpts above. Race-matching and resemblance hence, becomes integral to the egg donation process in order to ensure that the use of donor conception remains concealed from family members.

The fear of family rejection is reminiscent of feminist family theories on the family as a site of strength and collective survival as well as oppression and conflict (Allen, 2016: 213). The traditional ideal family, centres itself upon the notion of a racially homogenous, heterosexual couple that marries and produces its own biological children as legitimate (Hill Collins, 1998: 62). This family provides a private haven from public life and is held together through love and care. It assumes a sexual division of labour in which the woman maintains the home and the man works in the public sphere. This family is seen as biological and natural, stemming from heterosexual love. It serves therefore a "'dual function', as an ideological construction and a fundamental principle of social organization" (Hill Collins, 1998: 62-63). This ideology of the traditional family is a construction and a fantasy that superimposes itself as the ideal, marginalizing and delegitimizing family structures that do not follow this structure. The family hence, is an important social structure in the lives of individuals, but because of this traditional family ideal that continues to impose itself, the family then becomes a site of oppression for those individuals who do not conform to this constructed fantasy of suburban bliss. What is interesting and of import is that race takes the central and beginning stage as the marker of identity which assumptively allows donor agents and recipients to choose a donor in the likeness of the recipient, often leading to a prevalence of racial-matching. The concern being that this racial-matching is naturalized, seen as obvious and at times, highly mimics eugenic ideologies about the myth of racial purity and who can reproduce with who. In addition, race is then made to be a biological phenomenon that legitimizes family ties, as opposed to a social construct created with the intention of enforcing power dynamics and oppression.

CHAPTER TWO: DISCOMFORTS IN DISCUSSIONS ON RACE AND WEIGHT: A RESEARCHER'S POSITIONALITY IN THE FIELD

R: From your knowledge is there any scientific or genetic basis for race?

P: For?

R: Race.

P: Um, you mean um, you mean like, um, skin colour or something?

A stammer, a sigh, a rolling of eyes, an indication of frustration, discomfort, unease…these are the emotions I had to navigate during my interviews. Whilst I made it a point not to bring up the term 'race' as a start off in my interview, I instead chose to engage participants and their understanding by asking how they categorize donors. All pointed to the use of racial classifications. I then went on to use this to probe further, and with each question that involved race participants became more and more uncomfortable, uneasy, aware…As a researcher I felt the discomfort as well in the end. I couldn't understand why my participants were so defensive when answering questions about race and funny enough weight, when those are the classifications they impose. So perhaps, I wondered, it lies in my positionality, as an overweight, black woman.

This chapter proved difficult to conceptualize. Discomfort is not always verbalized, it is instead in the subtle change of body language, tone of voice and overall non-verbal behaviour. Leaving it subject to my interpretation, even more so than in the verbal communication that participants give me. But as a qualitative researcher, I cannot help but take notice of the way the behaviour of my participants changed when we discussed the topics of race and also at times weight. After much contemplation, I concluded that it may actually be linked to my positionality as an overweight, black woman. Cohen, Manion et al. (2011) make the argument that it is important for researchers to be reflexive and to acknowledge themselves whilst seeking to understand how they may play a part in or influence the research (Cohen, Manion et al., 2011: 225). But my positionality aside, after discussions with other scholars at a conference on Reproductive Technologies at UCT, I came to perceive this discomfort as data worthy of recognition. Discomfort is data, because healthcare is political. In the discourse of wellness, health and the altruistic notions that come with it in staff's attempts to alleviate the suffering of patients, the politicized nature of medicine is carefully concealed. But eugenics and neo-eugenics and the discourses around reproduction indicate that medicine is politicized and the discourse around reproduction and race often changes to suit the social structures of the time (Winant, 2000; Dyck, 2014).

Hence, when these political dynamics are questioned and brought to the surface, discomfort can only be the natural response. This discomfort confirms the nature of medicine as politicized and socialized and carefully concealed and hidden behind narratives of alleviating pain and finding wellness.

2.1 DISCOMFORT IN DISCUSSING RACE

R: Okay… Um, and then, in your donor pool, which racial demographic is the highest?

P: Black

R: And from the recipient side…

P: Um… (Sighs and rolls eyes). I would say black and white. Coloured very few, Indian very few (Participant 1, Interview 1).

R: And um, okay. Also I wanted to get a sense of why do you think egg donor agencies use racial categories to organize their donors and not for example a colour wheel?

P: What would a colour wheel look like?

R: It would be a wheel of different segments showing a range of complexions, from lightest to darkest. Similarly to what make up brands do with foundation.

P: Okay, uh, I see what you are saying. I think it is because most people, there are very few people who don't categorize themselves according to race. Um, yeah. People categorize themselves via race, by people I mean recipients and donors. So that would the first, um, if you ask a patient, what race they are. They would easily tell you. The same with donors. It's more of convention than anything else. We have for whatever reason, society makes it easier for people to categorize themselves according to race. So it would be more complicated and more confusing if we were to use a colour wheel. So for instance, the fact that I had to ask you what a colour wheel would look like is an example of why it is easier to categorize people according to race. Does that answer your question?

R: Yes it does.

P: Yah, I think, everybody classifies according to race. If you are Asian and you are looking for an Asian donor, how on earth would you begin to request that without um, using a racial classification? And even in the African context, as a black person, if I say I'm light skinned and I don't give my race, then a white person could be light skinned. So if all we've ever

been discussing in our communication without having met each other or even having met each other, if all we had used was light-skinned, light-skinned, that could potentially be a problem when the baby arrives and the baby isn't my version of light-skinned (during this exchange participant 2 starts to raise her voice and speak faster) (Participant 2, Interview 5).

R: Um…okay. So when you interact with the recipients, when recipients are looking for a donor what do you find are the common uh, kind of checklist…?

P4: You know there actually isn't any. Every single recipient is looking for something different. Black couples wanting a white donor, white couples wanting black donors. Um, some, they don't want the child to look anything like them and then others that want the child or the donor, to look exactly like them (responds seemingly nervously at first) (Participant 4, Interview 6).

"It's the most obvious trait to define our appearance if you want to put it that way… We're not putting them into a box. We're taking a blue print and working back from that. So if you gave me a picture of a landscape and said I want a picture just like that, I'm going to copy those colours onto your landscape and say 'you know what, this is the closest I could find to your picture'. And so that's what we work with…not sort of that we're doing it by choice, it's sort of by request" (said defensively) (Participant 5, Interview 6).

The above extracts may not appear to indicate anything of interest when read. Rather it was the body-language and tone of voice of the participants that alerted me to their discomfort when speaking about race, hence in bracket I indicate after the quote the change in the participant's behaviour that I observed. Participant 1 for example, in the above segment from my interview with them, appears to answer the questions and she does. What was interesting was that I made the observation during our interview that the only time she sighed and indicated fatigue was when I asked questions pertaining to race. In addition to this, she also rolled her eyes at my question regarding racial demographics during the interview. Suggesting a disapproval with my questioning and a feeling that my line of questioning is irrelevant. These attitudes that are strongly against discussions on race are part of an approach towards race that many South Africans adopt, one which Zimitri Erasmus refers to as the "colour blind approaches" (Erasmus, 2008: 7). The idea underpinning this approach is that due to the biological invalidity of race, race is non-existent and its use is a racist practice rooted in apartheid (Erasmus, 2008: 7). In my experience and

discussions, many South Africans perceive race as irrelevant and argue that many people in South Africa are too preoccupied with race and attempt to find it in all situations. The issue with this approach however, is that it does not allow for an open discussion on the prevailing racial stratifications that continue to affect society because of the colonial and apartheid legacy. Hence, whilst biologically race is invalid, the processes of racialization and the manner in which it continues to affect society are real.

Whether it be demographics, preferences, recipient choices, the participant, I suspect subconsciously, always sighed after questions on race. The next segment from my fifth interview, which was with Participant 2, I noticed discomfort in her tone of voice. Given the fluidity of race and the ease with which some people can slip and out of other racial categories due to their skin tone, I inquired about the use of a colour wheel in giving accuracy to the pigment of skin colour chosen if that was the intention of using racial categories. Participant 2, speaks to the obviousness of racial classification and the ease with which people can identify themselves according to race. She defends this argument by using the rhetorical question of how an Asian recipient would begin to request a donor without using race and proceeds to talk about the difference between a fair white person and a fair black person and how the use of “light- skinned” and terms regarding tone can be confusing. Participant 2 was raising her voice and I sensed a great deal of frustration towards my question. Due to ethical reasons I did not push the subject further, but did note the strength of her defensiveness.

This frustration and strength of defensiveness was similarly exhibited by Participant 5, in my sixth interview. Participant 5 became defensive during our interview, stating that they are not putting recipients and donors into a box, but are instead working with a blue print that already exists. Other donor agents indicated similar discomfort and frustration when speaking of the ‘obviousness’ of the use of racial categories (*See Chapter 1). What is fascinating about this is that prior to this point in the interview Participant 4 stated that there were no common traits recipients were seeking and she specifically used race as her example, and yet later in the interview Participant 5 stated that if I were to tell them I was looking for an egg donor they would automatically assume that I am looking for someone Black. Hence, within the data, there are at times inconsistencies due to the egg donor agents attempting to push a narrative that may not be critiqued or that speaks to inclusivity and diversity. What this indicates however, is that the discomfort and inconsistencies are speaking to a larger socio-political issue that donor-agents do not want to confront. One which perpetuates eugenic ideas, but in a different discourse. Given that South Africa is a “settler colonial” society, the sensitivities surrounding oppression often focus on race and

hence, the fear of retribution or accusations of racist practice is present (Dhamoon, 2015 in Gouws, 2017:23). I suspect that donor agents become defensive out of a desire to deflect critique on their use of racial categories, particularly given that many take the position that the use of racial categories is in itself is a racist practice.

My questions surrounding race were not meant as an attack, but rather as a means to understanding the role of race in the process of egg donation and why donor agencies employ those categories. I suspect that given the sensitive nature of race within South Africa as well as my positionality as a black woman, donor agents were uncomfortable and possibly wary of me accusing or problematizing their use of racial categories. Particularly given that I am a Black female UCT student and there were social activist student protests which were taking place in the country, questioning the ever pervasive effects of apartheid in South African institutions such as the university (Gouws, 2017). Hence, my positionality and the socio-political context of the time possibly affects and determines the responses donor agents give me. But rather I understood that donor agents and fertility staff are humans, who are also socialized as part of our society. My critique however, lies with the problematic nature of race's imposition in our lives, so much so that race-matching and resemblance are taken as given and natural means of choosing an egg donor. So much so that race is an intergral means of identifying people in South Africa and the first point in finding someone in one's likeness. So much so, that in this very thesis where I critique the biological conception of race, I am unable to escape the use of racialization that stems in "the look" and "the category" (Erasmus, 2017: XXII). This discomfort hence, is useful data. It indicates that there are further complexities and dynamics beneath the surface with regards to race that are yet to be unpacked and explored further.

2.2 DISCOMFORT IN DISCUSSING WEIGHT

Whilst I had anticipated participants discomfort around the subject of race due to the sensitive nature of the discussion in South Africa, I noticed that even when talking of other topics such as weight, beauty, and the requirements to be an egg donor, recipients were particularly defensive in their diction. This led me to consider that the discomfort in discussing these topics may have been influenced by my positionality as an overweight, black woman. But in addition, the defensiveness towards the classifications around mental health and weight, made me ponder the similarities between the desirability of a woman for egg donation and the classifications that made people undesirable for reproduction during the eugenics movement (Dyck, 2014: 8). Similarly, I wonder if perhaps this discomfort

hence, is indicative of an underlying social and political issue with other classifications used in medicine outside of race.

"The requirements are measured in a way that I don't like, because it's a requirement but it's worded negatively if that makes sense…But we don't want to put donors under unnecessary risk. And also, um, if you are, not overweight. Weight isn't the right word, but if your BMI is in a medically unhealthy range, you also need more medication to stimulate you when you are on the medication, the actual treatment, which makes it more expensive" (Participant 2, Interview 2).

"So they check the donor's health. If her egg reserves are low or she has fertility problems, they discuss it with the donor then and there. We don't just stick people and just um, sort of take advantage of them. It's their health, is just as important as the recipients…With regards to BMI, we don't want a weight that is too low either because your size of body determines how the medication will be metabolized. So, if you are too large the medication will need to be more, and if you are too small, the average dosage of medication is going to be too high" (Participant 4, Interview 6).

"Because you know some donors can have wonderful childhood photos and not be that attractive and vice versa. You know what, there's no, but this isn't say, like a sort of a beauty contest anyway. So um, I mean, you know there's only so much you can kind of…well it's actually out of everybody's control isn't it?" (Participant 7, Interview 7).

Participant 2 indicates while discussing weight that she is uncomfortable with the use of the word 'overweight'. She attempted to construct her diction in a politically correct manner by using the words, "medically unhealthy BMI". Whilst I understand her defensiveness, it is my understanding that weight is a construction in medicine in itself. Weight to height ratio may not always be an accurate indication of health, due to the fact that muscle mass also adds to one's weight. An accurate measurement with regards to size therefore, may have been preferably the percentage of body fat, or to have a range of weights within which medication still proves effective. My interpretation of this discomfort I suspect lies in the socio-political issues surrounding weight, "fat-shaming" and the ways in which overweight and obese people have been stigmatized and ostracized within society due to their size (Myers and Rothblum, 2004 :112). Overweight women, in particular overweight women of colour have been deemed unattractive due to Western standards of beauty and aesthetics, as well as a burden to society and health due to their excess weight (Strings, 2015). As Ama Ata Aidoo writes in her book, *Changes*,

"The days when being fat was a sign of prosperity and contentment are long over. You and I know that these days the only fat people in the world are poor, uneducated women in the

Third World and unhappy sex-starved women in the more affluent societies who are supposed to eat for consolation" (Aidoo, 1991: 36).

As the above quote indicates, being overweight is seen as an unhealthy practice condoned by Third World Cultures who do not understand health, or overweight women in affluent societies who are deemed unattractive and without love, so seek comfort in food. Being overweight and having dark skin is deemed unattractive, in addition, the phenomenon of these unattractive attributes are gendered. This is due to the Western standard of beauty which has imposed itself globally through the media (Shaw, 2006). The requirements of being an egg donor therefore, whilst in the interests of the health of the donors, align themselves with the current politics of beauty and aesthetics, and it is an awareness of this, as well as my positionality, that most likely makes donor agents defensive.

I believe an awareness of these social phenomena makes donor agents defensive, as Participant 4 was very quick to point out that they also do not allow donors whose weight is too low to donate. Hence, while there are medical procedures put in place to protect all participants in this process, there also seems to be an underlying awareness on the part of the donor agents of the socio-political nature of categories in medicine and the problems they can cause by aligning themselves with political aesthetics. Participant 7 indicates this when she is quick to note after stating that while some donors may not be deemed attractive as adults despite having cute baby photos, the process however, is not a beauty competition. The need to defend the egg donation process as not being a beauty competition, again indicates the need on the part of donor agents to defend the process of egg donation and avoid any perceptions that there are politics of beauty and aesthetics at play during this process.

Therefore, the discomfort that donor agents display in their diction and body language is relevant as data. It indicates that there are social and political issues beneath the surface of the egg donation process. Whilst infertility treatment is presented as a wonderful way of allowing infertile couples to conceive, further probing and reflection indicates that the desirable traits specified by doctors, donor agents and recipients, do tend to mimic eugenic movement structures of who/what was worthy of production or not. This discomfort I suspected extended to other categories outside of race, such as weight due to my positionality as the researcher, but the majority of the discomfort and frustration, always stemmed from the topic of race. The need to subvert problematic socio-political issues arising from the process of egg donation as the interviews unfolded were pushed back by strong sentiments and narratives of altruism and the goals of health and wellness. The irony, being that similarly during the eugenics movement, eugenics was presented not as a racist

program about perpetuating power dynamics, but a scientific program in the interests of nationhood and health.

CHAPTER THREE: ALTRUISM AS DEFENSE IN THE SHAPING OF A NARRATIVE

Feminists who study the family have made the argument that whilst the family is a site of strength, solidarity and collective survival, it is also a space where oppression and conflict take place (Allen, 2016: 208). There is no black and white, no binary, no dichotomy, but rather the socio-political issues surrounding egg donation, like race, are not clear cut. To avoid the discomfort of these uncomfortable truths, donor agents push back against possible negative depictions of egg donation by employing altruism and emotional narratives. To deflect the discomforts around race, weight and other categories enforced, the ideology of the family and of making families whole, is employed. Making egg donation therefore, not just a process, but a narrative in which infertility staff put forth an ideology of the search for wellness, meaning and family. This narrative is a fairy tale of hope and triumph, that begins with a couple that fell in love, then struggled to naturally conceive their own child, so they enlist the help of fertility specialists in the hope of ultimately having a baby.

There are altruistic sentiments and emotional narratives that make up the fabric of the nature in which both recipients, egg donors and egg donor agents, come together to aid in the assistance of completing this story. Whilst race and weight were categories that caused discomfort during the interviews, these narratives of altruism and emotional connection were freely given with comfort. Human reproduction after all, has long been of import to human beings, since time immemorial. The struggle to conceive a child due to infertility is a painful experience. It is an experience that often leaves its sufferers feeling much pain and it has for a long time before been a state that brought with it much shaming and stigma (Dyer et al., 2004: 964). As a result, whilst I went into this study expecting to simply observe and speak to those who work in the field about couples endeavours to have a child and the desires they seek in the egg donors they choose, I was confronted with the discomfort that comes with researching sensitive topics. Constantly at every turn rethinking my goal to make the link between egg donation and race, in a way that does not harm the participants and patients who experience this pain and joy as part of their daily existence.

As with all things the answers were not so clear cut, but proved instead the complexity and ‘grey matter’ that lies at the centre of most, if not all, social phenomena, particularly race as this study has made evident. But in an attempt to shy away from uncomfortable truths surrounding social phenomena such as race, fertility staff often push back with narratives about the resilience and hope encompassed in the process, in which a family’s dreams are made true. And interestingly in these narratives of pain, the idea of a family being legitimized through biology and resemblance is further made evident, of which at the heart of this resemblance and biology is the ideology of race.

"It's very personal to me and every time I help someone it feels like I'm helping my previous self through the struggle…So most of the time when people meet, this is the normal fairy tale right? So then you get married, decide you want to have a child together, you have sex and then you have a baby. But then, it doesn't always work like that…So when they come to us, they're normally at a point where they've been trying for many years…and then the recipients have to go through a grieving process, where they give up on the dream of having a biological child, and for some people that grieving process takes a week, a month, a year, some people never get over it" (Participant 3, Interview 3).

P: So he said, 'if you want to carry your own child, then you need to um, to consider egg donation…I was so upset by it I was completely devastated…

R: Mm, okay, um, what did you find was the hardest part of the journey?

P: Um…Sho. I'm just trying to think now…Well sort of the fact that I had to consider using donor eggs was the hardest part and that I couldn't use my own eggs for the IVF, that was the hardest part… (Participant 8, Interview 9).

Above participant three speaks of the pain and grief that patients endure upon realizing they are infertile, after numerous years of attempts to conceive a child. By the time patients enter the doors of donor agencies they are disappointed that the child will not be conceived of using their eggs. Egg donation hence, then comes in as an option for them to still carry a child and have the experience of being pregnant, even if the child will not have their genetic make-up. Of importance is the language employed by participant three. She refers to the process of accepting the use of donor tissue as a 'grieving process.' She uses such strong language to emphasize the pain endured by recipients in this process. It is not the relief that treatment is available, affordable to them and allows them to go through the pregnancy process, the predominant emotion is one of devastation. Indicating that genetic material holds utmost significance to patients in the creation of a family.

Participant 8 echoes these sentiments when recounting part of her infertility journey, noting that what she found most difficult was having to use an egg donor's eggs, as opposed to her own tissue. Hence, while the end result (the birth of the baby) brings much joy and warmth to the hearts of recipients, the process of egg donation is not an easy one. And it is not an easy one particularly because the expectation is that a child is legitimate and ideal through having one's own genetic material passed on to them. Further enforcing the ideology of an ideal family being connected by biology, part of this biology of course, being race.

In addition, the donor agents (some of them previous patients) have an emotional connection to their work. Whilst the world of egg donation and the process within the private health care

system is commodified, along-side this there are strong sentiments of altruism and 'giving back' from the staff that have chosen to work within this field. What is interesting is the comfort with which the below narratives are given, is a sharp contrast to the way in which race is discussed.

"And…. Then I enjoyed it…. Just being able to help someone and share in that excitement and that joy when you get that e-mail or that phone call or they walk in here and they are bursting with happiness that they're pregnant…And obviously there is times where um, the pregnancy is not successful, but then, you know, we cry together. So yah, we cry together, we laugh together, we share in all the emotions." (Participant 1, Interview 1).

"When I was 16, I had a friend who was diagnosed with ovarian cancer and she had to have her ovaries removed, so I knew the only way she could have children one day is through an egg donor. And then that's when I had to ask myself. Because I wouldn't want someone to do something for me, that I am not willing to do myself. To me becoming an egg donor was an active thought and I signed up and I was chosen and I did 6 donations. And then started my own company and yah… (Participant 4, Interview 4).

The staff I consulted, six donor agents, a fertility nurse, a fertility coach and a gynaecologist all pointed to the idea that this work, while it is work, has an emotional component that they cherish greatly. There is a sense of altruism and 'giving back' to a couple that has been yearning for a child that makes their experience of this work very emotional. Donor agents hence, portray their industry as one of family creation in which the dreams of a couple to have a child are made true. There is no immense effort to address or discuss the stratifications within the industry and the issues surrounding fertility treatments, despite the numerous ethical debates and social issues that are part and parcel of it. What is of interest then is the sharp contrast in the narratives of altruism, which are freely given, against the discussions on race, which are strongly avoided. All staff but one displayed discomfort discussing the subject of race. It is my analysis that because egg donation and race are such contested topics, the comfort and ease with portraying egg donation as an altruistic process that allows the dreams of a family to come true is portrayed. Similarly to how academics study a dichotomy between egg donation being altruistically motivated or financially motivated, with egg donor agents there is also a dichotomy, that egg donation is either an altruistic process that helps treat infertility to make families whole, or it is a controversial money-making act that allows the production of designer babies. The question I pose is why it is not possibly both? The employment of binaries within social phenomena is not one that appears to aid our understanding of them.

These altruistic narratives I would argue are subtly concealing the ways in which Assisted Reproductive Technologies are perpetuating certain ideas about race and allowing for a process of neoeugenics. Hence, whilst it is important to be sensitive to the pain and suffering of others, it is still relevant and necessary to examine the problematic nature of these technologies and the stratifications they create in order to ensure reproductive justice for all. Health has and will continue to be an area of research that requires sensitivity and attention to ethics. But health is also a relevant field of study in the social sciences for indicating power dynamics and social stratifications that continue to play themselves out in our lives. With close examination, we can see how medicine and its narratives have adjusted to the political moments of the time, and whilst, the human genome project indicated that there is no genetic validity in race (Roberts, 2011: Preface), ARTs have brought forth a resurgence of the use of race as a naturalized and scientific phenomena, beneath the guise of a search for wellness and making families.

EPILOGUE

I'm sitting at my desk, a piece of paper before me with scribbles of words coming together to make some sort of brain storm, some sort of connections within all the data I have amassed. I think about Assisted Reproductive Technologies in social sciences and how little literature there has been within the South African context, yet I am so struck by how there are vast similarities between what is happening in the literature from other parts of the world and what is happening here in Cape Town. And I suppose given that South Africa is a previously colonized nation that then endured apartheid whilst other African states reached decolonization, I imagined that there would be a different way of seeing race in ARTs in Cape Town. But instead Cape Town fit the status quo, it lived up to its Global City status. Donor agents, even having not studied social science, were all able to point to relevant social issues within infertility treatment that they examined and give their opinions on solutions moving forward when asked what they would change. They engaged social issues such as Gender, Class, Cross-Border Reproductive Care, stigma towards infertility, the laws surrounding reproductive technologies and much more. But none, absolutely none, thought that race or race-matching was indicative of something worthy of investigation and questioning. No one questioned the idea that the first step in choosing someone who looks like you comes in matching race. No one questioned that perhaps the desire to race-match would perpetuate ideas of the myth of racial purity. No one questioned desirability or anything close to eugenics at all. It was as if race was the most natural, accurate and desirable means of choosing a donor and was not at all an issue, even if patients were doing such to conceal their use of these technologies out of fear.

CONCLUSION

In conclusion, race plays a central role in the process of selecting an egg donor in Cape Town South Africa. The Assisted Reproductive Technologies indicate the pervasive way in which race asserts itself in our lives and these technologies reinforce it as though it is a natural biological phenomenon, as opposed to a social construct. Recipients and donor agents reinforce this use of race and often tend towards race-matching, the ensuing effect being not only a naturalization of race, but a resurgence of eugenic ideas around the myth of racial purity.

Racial categories were used to organize donors on the agency websites and when questioned about the use of these racial categories fertility staff pointed to an 'obviousness' of the relevance of race for identifying a donor despite race being a fluid social construction with no hereditary significance. This naturalization is very prevalent, such that recipients who do not wish to racially match have to make that known to the donor agents in the event that it is the donor agent who will search for a donor for them. The use of race was justified as the best way to seek out a donor that resembles the intended mother. While many recipients seek resemblance between themselves and the chosen donor, the first step in the process of identifying this donor is always race. Race is the central marker of identity within the process of egg donation. The matching of race and the desire to achieve resemblance often stemmed within a desire to conceal the use of reproductive technologies and donor tissue for conception. The desires to conceal stemmed from the stigma regarding infertility, conservative cultural ideals and religion. But the leading factor in the desire to conceal was the recipients' fear of rejection from other family members. Many recipients who seek resemblance in a desire to conceal fear that their child will not be accepted or as loved if family members are aware that donor tissue was used to conceive the child.

A contradiction that presented itself during this research was that whilst donor agencies categorize their donors using racial categories and naturalize the use of race in the process of selecting an egg donor, staff exhibited discomfort and at times frustration when probed on race. Whilst non-verbal communication is difficult to conceptualize, this discomfort remains to be relevant data, indicative of social and political issues beneath the surface. In addition, fertility staff also displayed discomfort when discussing weight, leading me to conclude that my positionality as an overweight black woman, may have had an impact on the research and the way in which participants engaged with my questions.

This study found that there were strong narratives of emotion and altruism on the part of the fertility staff, to push back against possible controversial views on egg donation. This altruistic discourse is relevant because it subtly conceals the problematic power dynamics

that are perpetuated by these reproductive technologies. Similarly to how eugenics was a movement about controlling undesirable populations and maintaining the myth of racial purity, eugenics presented itself as a science with the intention of building nationhood and advancing health. Similarly these altruistic narratives employed with regards to egg donation conceal the problematic way in which reproductive technologies reinforce the use of race, perpetuate unequal relationships and stratifications and mimic eugenic movement ideals of the myth of racial purity. The employment of binaries in our understanding of social phenomenon is not always helpful, this appears to be the case with race and its role in egg donation.

Finally, there are two misconceptions about eugenics that I have observed. The first is that eugenics ended with Nazi Germany. When people think of eugenics they often think of Nazi Germany and the concentration camps that killed those deemed undesirable. They assume that eugenics is a thing of the past, steeped in a time when science was used to push racist political agendas. The second misconception is that eugenics only means 'better birth' and genetic improvement. They think of 'better birth' and today as 'designer babies' along with prenatal testing to screen out traits deemed defective. The issue is, eugenics did not end with World War II, eugenics persisted and changed its discourse to facilitate the political shifts of the climate, manifesting itself presently in population control programs and reproductive technologies. In addition, whilst many view eugenics as 'better birth' and a search to genetically improve one's family line, I view it differently. Eugenics is not so much about better birth as it is about the myth of racial purity. The eugenics movement dictated who could procreate with whom to maintain the myth of racial purity, concealing itself in a rhetoric of nationhood and health improvement. Similarly, egg donation mimics this, bringing forth a perpetuation of these ideas. Egg donation perpetuates ideas about the myth of racial purity through racial-matching and a naturalization of race. Similarly to the eugenics movement, it conceals the power dynamics it perpetuates in the discourse of resemblance and narratives of altruism. The Assisted Reproductive Technologies have brought treatment and hope to those struggling with infertility and indicates the advancement of science and technology within the health sector. However, the persisting power dynamics surrounding race and desirability have come to manifest themselves within these technologies, indicating that as time changes, the discourse within medicine and science shifts itself to accommodate the politics of the time. For social justice to be achieved, these power dynamics must be identified and then dismantled to ensure just experiences in society for all.

APPENDIX A: APPROXIMATE INTERVIEW SCHEDULE

INTRODUCTORY QUESTIONS TO ESTABLISH COMFORT

- May you please explain to me what your role is here at…?
- What are your responsibilities in this occupation?
- Is there a reason you chose to work within the field of fertility treatments?
- Do you enjoy this work? If yes, what is the most fulfilling part of having this job?*

EGG DONATION PROCESS QUESTIONS

- May you please explain in detail how the process of egg donation is conducted here at …? From both the side of the egg donor and then the recipient.
- When you interview potential donors what are typical questions you will ask? *

  May you please explain in detail the requirements for being an egg donor?
- Why are said requirements put in place?
- If donors are compensated, what are donors compensated and why?

PROBING FOR RECIPIENT'S POSSIBLE DESIRES AND POSSITIONALITIES

- Do you interact with egg recipients in your occupation?
- Are there factors/traits recipients seek in donors which do not affect the outcome of a successful pregnancy? If so what are they? Probe for possible insights into this. *
- If there is a website or online database of donors, how much information about donors is given for recipients to shift through? (ask for access*)
- How much does the process of acquiring donor eggs cost recipients?
- What are the general demographics of recipients that seek donors here? Examples: occupation, race, age, etc.
- Are pro-bono cases or clinical trials that allow for free treatment ever conducted?*

UNDERSTANDING PHYSICAL TRAITS, RACE AND ITS ROLE

- What advice, if any, do you give recipients about choosing a donor? Probe reasons?
- From your observations, are there certain physical traits recipients often seek in egg donors? Probe why. What are reasons sometimes given for this?

- Here at…, how do you categorize the different donors you have? Probe why. [Note if participant brings up subject of race].
- Do you use racial categories for your donors? If so what are they? And why?

- How do recipients engage with race when choosing an egg donor?
- In cases, where a picture is sent to you and you select possible donors for the recipient, how do you choose? How does participant engage with race? Probe reasons for this.
- In the donor pool, which racial demographic is the highest? Probe for insights.
- In the recipients, clients, which racial demographic is highest? Probe for insights.
- From the selections, which racial category is chosen most? Probe.
- Have alternatives to racial categorizing been considered, given that there is scientific backing for the idea that race is not hereditary?*

- If recipients seek out racial traits, what if any are the reasons given for this?
- If reasons are not given, what is your opinion on the role race plays in the selection process?
- If recipients seek a donor who is of the same race, please elaborate on why recipients seek this resemblance?
- Are there recipients that choose donors of a different race? What, if given, are the reasons for this?
- What are your reactions to recipients who choose not to match the race of the donor to theirs?
- Do different races seek different racial traits? [For example do blacks prefer complexion and whites prefer focusing on hair and eye colour].
- Finally, are there any other insights or information you believe is relevant that has not been covered yet in this interview?
- Would you be willing to do a follow-up interview?

APPENDIX B: CONSENT FORM

Research Topic:

RECIPIENT CHOICES OF DESIRABLE TRAITS IN EGG DONORS IN CPT, SA

Names of principal researchers:

RUFARO MOYO

Department/research group address:

DEPARTMENT OF SOCIOLOGY, UNIVERSITY OF CAPE TOWN

Telephone:

0609300567

Email:

rufaro_moyo@yahoo.com

Name of participant:

Nature of the research:

INTERVIEW

Participant's involvement: RESPONSE TO QUESTIONS

What's involved: INTERVIEW

Risks: INDIRECT IDENTIFICATION

Benefits: REFLECTION AND INSIGHT

Costs: N/A

Payment: N/A

• I agree to participate in this research project.

• I have read this consent form and the information it contains and had the opportunity to ask questions about them.

• I agree to my responses being recorded and used for education and research on condition that my privacy is respected, subject to the following:

- I understand that my personal details will be used in aggregate form only, so that I will not be personally identifiable

• I understand that I am under no obligation to take part in this project.

• I understand I have the right to withdraw from this project at any stage.

Name of Participant: _____.

Signature of Participant: _____.

Name of Researcher: _____.

Signature of Researcher: _____.

Date: _____.

APPENDIX C: SAMPLE INTERVIEW

KEY: R → Researcher. P→ Participant

PARTICIPANT THREE, INTERVIEW THREE

R: Okay, so first things first, please may you explain to me what your role is at ____?

P: So, I founded the company, along with my business partner __, um, ten years ago. Um, so we originally it was just her and I, but it's grown and we now have other people. So I play a strategic role in the agency, I look for new opportunities and I manage the business.

R: Um, Okay so you manage the business…?

P: Yah, yah, so when we first started we had um, because I've been through infertility myself, I have a very close affinity and empathy with the people that are going through infertility. So I used to look after the recipient couples and my business partner, __, looked after the egg donors, because she used to be an egg donor. So we had personal experience of both sides of it. Then as we grew we had two people working on recipients, two on donor, three on recipients, three on it. So we've grown and we're a team of 9. So I, although I won't say I'm no longer involved in the day to day, because I'm actually interviewing two donors after our meeting. So we, we like to…I like to take part in all sides of the business. So I do a bit of everything, but what I do now is new opportunities. Um, yah.

R: Um, okay and then, is there any reason you chose to work in this field?

P: Yes, it's very personal for me, so when I was going through infertility, it's a very lonely place to be infertility and for a lot of people it's a shameful place, it's a lonely place, and not everybody talks about it. So when I was going through infertility I went on the internet and I was on forums and support sites and stuff like that, and then um, and then I had started a blog about my infertility journey and I had blogged, well towards the end of it actually, and then a publisher approached me and said, 'Why don't you write a book about your story?' So I wrote a book about my story and then through that, someone, like, someone once said to me, 'why don't you do something like infertility because it's something you're so passionate about?' And then that's when I started __. So it's very personal to me and every time I help someone it feels like I'm helping my previous self through the struggle.

R: Uh, okay and then may you please explain to me in detail the process of egg donation?

P: Okay, so um, with egg donation there are two sides to the cycle, a donor side and a recipient side. I'll talk about the recipient side first. So most of the time when people meet, this is the normal fairy tale right? So then you get married, decide you want to have a child together, you have sex and then you have a baby. But then, it doesn't always work like that. So what happens is that people start trying and trying and trying, it doesn't work. They go to see the gynae, the gynae says, 'well, try these pills' and then that doesn't work, and then they end up at a fertility clinic. They have a whole lot of tests and investigations and then they find out, they try and see where the problem is, whether it's a male fertility problem or a female fertility problem. And then they try, they normally try Artificial Insemination first, and then they try IVF. And when all of those things fail, which is normally after a few years, they will get to the point where the doctor says, 'Look, it doesn't look like it's going to work with your own eggs because your age or you have what we call diminished ovarian reserve, you have fewer eggs than the normal average woman. You're going to need an egg donor' and then the doctor will say, 'contact these egg donor agencies' and then they come to us. So

when they come to us, they're normally at a point where they've been trying for many years, there's a lot of failures, a lot of heart ache. So they get to us and they're kind of quite sad in a way, because nobody grows up thinking you're gonna have an egg donor baby one day. You think, 'I wonder if one day my child will have my funny eyes, or my dad's funny sense of humour, or something like that.' So, and then the recipients have to go through a grieving process, where they give up on the dream of having a biological child, and for some people that grieving process takes a week, a month, a year, some people never get over it. But for those who are able to get their head around the fact that, 'okay so the baby won't be from my DNA, but it will still be my baby, I will carry the baby.' Then they come to us to look for a donor. Now what happens is we sign up to our password protected site and they'll go look at all the donors. We've got for example 500 donors that are available to donate immediately. And then 99% of the time, the recipient will choose a donor that looks like the mom to be. If she's tall, blonde and blue eyed, she'll choose a tall, blonde and blue eyed donor. If she's a short, dark African lady, she will choose a short, dark African lady, so that hopefully the baby looks a little bit like the mom. Most of the time it's the donor egg with the husband's sperm, so the baby will look like the husband and also hopefully a little bit like the mom. So we obviously don't get an exact clone of ourselves, but for example if she's tall, she'd like a tall donor, if she's short, she'd like a short donor. We have very, very few people who take a donor from another race, less than 1% of the time does that happen. The only time it happens is with an Indian couple, who might choose a dark skinned Caucasian donor. But we've never had a white recipient choose a black donor or a black recipient choose a white donor, because they want the baby to look like them. For Indian, I think for some Indian couples, if they're quite pale, they can choose a Caucasian donor that's quite fair. But otherwise they don't go. So they will choose a donor, they type in the search criteria, show me all the donors who are tall, black and um, and whatever frame, Cape Town. Then they will go to each donor's profile and they will read what the donor has written and they will try to find a donor who they find a connection with. They try and find somebody that's like them. So the donor will write for example, that she's very easy going or that she's very sporty or that she's very academic or that she's very artistic, and recipients most of the time choose a donor that is like them. So the donor will write, 'One of my favourite ways to relax is to go paint in the fields,' and the recipient will go, (gasp) 'That's just like me!' And then they choose a donor like that. Other people are more sort of pragmatic and practical, you know, 'I don't care about sporty or not sporty, but academics is very important to me, because we're an academic family, so I want someone with a university qualification.' Um, so yah. I always like to give the example of…I told you I can talk a lot hey (Laughs)

R: (laughs)

P: I always like to give the example of, these two recipients that I had. One of them ended up with twin boys and the other single boy. The one, she chose a donor, and it was very important to her to find a spiritual connection with the donor. So she consulted a fertility astrologer and she got the donor's birth chart details, her birth chart details and matched the donor that astrologically aligned to her. And then…both of these recipients I've actually become friends with them. They're both awesome. And the other woman, she's a lawyer. She did an excel spread sheet, um, she was…she is a coloured lady and she wrote down all the qualities that were important to her, she gave them weightings, she put the donors weighting in, her weighting in and she did like a whole statistical analysis based on what was important, that's how she chose her donor. And so you have two completely different ways of choosing a donor and both those donors were absolutely perfect for those ones and beautiful children were born, they love them. You know. So people choose, recipients choose donors for all sorts of reasons, but the most important aspect full stop is the physical

resemblance to the mom. Now a lot of people who don't know will say, 'Oh, designer baby!' You know they try to do a designer baby, it's not true. They want someone like them. They don't want…if she's short and dark, she's not going to choose a tall and blonde donor. You know. Uh, so it's like that. Another interesting thing is that, with a lot of African recipients. We get a lot of African recipients from Angola, and Zimbabwe and those places. They choose donors upon skin tone, complexion. Very important to them. So if they dark, they want a dark donor. If they're fair, they want a fair donor. They're less concerned about academic qualifications or musical or sporty. But skin complexion is very important to them. So that's okay, okay, so then what happens, they choose a donor. And then, okay let me stop the process there. And then from the donor's point of view, we go there. Now we spend 99% of marketing spent on recruiting donors because recipients want a choice. I can't just have one donor for one recipient, I need to have 15 donors for 1 recipient so that they can choose. So we recruit donors through all sorts of ways. Articles, word of mouth, social media, etc. The donors sign up online, they go through quite a rigorous screening process. We screen them, we interview them, they gotta put in a very long application form, there's a whole lot of disqualifiers. Age is the most important, you've got to be between 19 and 32. Um, BMI, you can't be too skinny or too overweight, because the medicine won't work as well. No hereditary psychological disorders in the immediate family, um, uh, that's sort of thing. You can't use drugs, blah, blah, blah. Then we interview them, they have a psychological assessment and a medical assessment. So then the recipient chooses the donor and what we do is, we send the donor to the recipient's doctor where she's been, where the recipient's been for many, many years. The doctor will meet with her, tell her the medical details, the donor will have a gynaecological examination, she'll have blood tests done. If everything is alright, then they put the donor on the pill and the recipient mom on the pill, so that their cycles are synced. Their cycles are synced and then they'll stop medication on day 5 of their cycle, the eggs will come out day 14 of the cycle, eggs are removed from the donor, they're fertilized with the husband's sperm in the laboratory and then the embryos are put in an incubator and then one or two embryos are put in the recipient mom and then 14 days later she will find out if she is pregnant. That's a very high level quick summary of how the process works.

R: Um, Okay, uh, with the psychological assessment, you don't take hereditary mental illnesses, like Bipolar disorder…

P: Bipolar disorder and schizophrenia…are the exclusions…

R: Okay

P: So I always say, I always say everybody's got a crazy aunt or a crazy uncle, that's fine okay, and lots of us are on antidepressants, that's also okay. But if you've got two psychiatric medications, like Ritalin and antidepressants you can't donate. Um, some epilepsy drugs you can't donate. So we always tell donors the purpose of the psychological assessment is three fold. One to make sure there is no hereditary psychiatric disorders, uh like bipolar and schizophrenia. Number 2 to make sure that the donor is healthy enough, mentally healthy enough to donate. So donating must add value to her life, it mustn't take away from her. And number three to make sure that the donor understands what she's doing, she's thought about the consequences, she's thought about the future. Um and I would say like, like even for donors who have been through trauma and abuse, physical abuse like rape and whatever, it's such a positive thing to do with your body. You're helping and that is actually so healing. Very, very few donors fail the psychological assessment. There's been one or two. The one the donor was suicidal so the psychiatrist, psychologist felt that she needs to

sort herself out first before she went through the donation process and the other one had told a lot of untruths and the psychologist felt like she had big issues. So very few fail unless there's hereditary stuff. But we screen our donors so well. We're the only agency I think in the country that meets face to face every single donor. We interview them first before we put them forward and we know, after being in this industry for ten years, we know what's in. We say to our donors the biggest thing we need from you is commitment. It's a big commitment. Recipients are investing so much of their heart, soul and money into this process that unless you are 100% committed unfortunately, we don't want you to be part of the process.

R: Um, do you compensate the donors?

P: We don't, but the clinics do. Donors get paid R7000 for their time and efforts. They do not get paid for selling their eggs, you're not allowed to sell your eggs. So whether they make one egg or twenty eggs they get paid R7000. That's to cover their petrol to get to the clinic and their time off work and stuff.

R: Um, so on the online catalogue…

P: Online database…don't call it a catalogue…

R: Sorry

P: Yah, yah, its fine.

R: The online database, um, do the donors decide how much information they share or is it…the…

P: So what happens, egg donors are completely anonymous, right? So there's no identifying information on the website…on the database. So we give each donor a pseudonym and we've got a standard questionnaire that they fill in. Um, and I'll give you access to our system so you can have a look, I'll let you sign in as a recipient and you can view the donor profiles. You'll see there. So we ask them first, eye colour, hair colour, height, weight and then we ask them family history, what's the height, weight, eye colour, hair colour of your mom and dad, your granny, your grandpa and all that information. There's a medical questionnaire, you've got your education questionnaire, so everyone has got the same profile. But they fill it in, so we ask them like, 'What's your favourite colour?', 'Describe your personality' and that sort of thing. So that's there, but they have to answer every question.

R: Okay and then, how much does the process cost the recipient?

P: A lot, a lot of money. In Joburg it will cost you about a R100 000 per attempt, in Cape Town it will cost you about R85 000 per attempt. There are, there is a government hospital, that offers it for much less, between R 15 000 and R20 000. Um, that's at Groote Schuur. But you have to stay within the catch group area or something like that and there's a long waiting list. And then there's Tygerberg Hospital, also offers a much cheaper version of this um, and then in Joburg, I think Steve Biko hospital also offers slightly cheaper. Otherwise it's all private and it's very expensive.

R: Okay, so on the database, when I go into the database, are there already categories, or do I have to type in what I am looking for?

P: So if you don't type in any search filters you get all the donors. But then you can search eye colour, hair colour, race, um and area. So you'll see…like if you're looking for a donor you'd type show me all black donors in Cape Town and you could put in height, or and also height. So you can filter out, but we always say to people if you willing for example to look at

blue eyes and brown eyes, then you get, you know, more donors. But if you're very, very particular, the donor must be 1.6, must have blue eyes or whatever, gives you much less to choose, but then it's absolutely up to you.

R: Um, okay and then, is there ever a time where you will give recipients advice about how to choose if they are not sure?

P: Absolutely. It's a, it's a service we offer and they often take us up on it. So what they say is, can they send me a photo of themselves and then I will match. Then I tell them, go online and give me a shortlist of your top five that you like and I will tell you of those five, which most closely physically resembles you and I'll give them some advice on that. And that is something that we offer because it is an scary process, just choosing your child's future DNA or…so it is a difficult…we do help them a lot and some of them want to meet with us or they…half of our recipients are from the overseas...yah…and of that probably 70% are from Australia. Because egg donation Australia is really difficult to access and then it's so difficult. You're not allowed to pay the donors at all, it's gotta be…it can't be anonymous. So there are very few people in Australia that want to do egg donation, so Australians have to travel to do egg donation. And whether they come to South Africa or America or Europe, which is really far…um, Spain is the egg donation capital in the world and they get a lot of Europeans. We so far it's very difficult for us to get European customers, we'd like to…but…

R: And then um, from your observations, how much time do recipients take on average to choose a donor?

P: It's so different, because like, first of all, there's a lot of people that sign up. So we send them an information pack, um, some of them never respond. So some of them could be looking for months and months and months, waiting for their right donor to show up. But I'd say most take three/two weeks at a time to choose their donor…depending on where they are mentally, what space they're in, how far along they've gone their acceptance route.

R: Okay, and then I wanted to ask, with the different filters that recipients use when looking for a donor, which do you find are the most common?

P: Race. Area. Okay, area and race. You can pick a donor who lives in Joburg, but it's going to cost you more. So areas the obvious thing, you want a donor who lives in your area. Then race is the first thing. And then, depending on, on whether it's a Caucasian recipient or an African recipient, um, because then things like eye colour and hair colour will obviously, won't apply to the African recipients, it' s more the Caucasian recipients. So they would say that. So, as I said, whatever, I'm generalizing very much now but mostly what we find is, with the African recipients, it comes down to a physical match is the most important. Whereas with Caucasians they have more flexibility potentially with the physical match but then the softer issues are a little more important like academic qualifications and sporty or music and stuff. And just another aside, again generalization, I've got no stats to back me up, but my feel is that most African recipients will not disclose to their children or to anyone else that they have received a donor egg. Whereas half of the Caucasian recipients will disclose. So the disclosure rate among the Caucasians is much higher than it is amongst the black population. And I think that's got a lot to do with how fertility is seen as part of your social standing within the community from the different…from the different races and ethnicities.

R: Okay, and then the different racial categories, please list them for me.

P: So it's Caucasian, Black and what we call mixed race or Coloured, because a lot of internationals don't know coloured. They know mixed race. Yah, and then Asian.

R: Okay, with with the Asian…

P: Oh, sorry! And Indian…

R: Oh, Okay. Um, and then I wanted to ask in the donor pool, which race is the highest, like the highest represented?

P: Um, it's very much demographic according to the area. So for example in Joburg we've got many more black donors than white donors, but in Cape Town we have many more coloured donors. So it's very much demographic. But what I can do…if you e-mail me afterwards and ask me that, I'll give you an exact breakdown of the donors per region per race group. I can provide that information. Just remind me via email.

R: Okay…then, then I wanted to go back to what we were talking about earlier, about the designer babies vs. seeking resemblance. I've been finding scholars are taking different positions on this, where some feel it's making a designer baby and others feel that it's more about resemblance. Um, and I just wanted to try and understand, why recipients place a huge importance on having a child that resembles them, if that makes sense?

P: Well, you can understand, for those, especially for those who do not want to disclose, which is basically most of our black patients and many of our Caucasian patients as well. If they choose not to disclose that the child was conceived with a donor egg, physical resemblance is of the utmost importance. You know, like it's hugely important. So that's the um, that's the main reason for it. But even for those that disclose, having a baby that looks like them, that looks like me, is something that I think is innate in all of us. And what's interesting, I've spoken to friends of mine who made donor egg babies and they say, 'people automatically look for similarities' and we do it without thinking. You have a child they go, 'Oh, she's got your smile', 'she's got your eyes', something like that. Even when it's not their own genetic material, people will look for resemblance, that's what we do as human beings and I don't know if there's some…dual psyche/social understanding about that one, maybe about why we have, a you know, we keep our young to ourselves. So that kind of…there's something within that thing, that that drives it. The truth is, I mean, a funny sort of aside is that, we always joke about it. Recipients never come to us and say, 'I'd like a donor of average intelligence because I am average." They don't say that. They always want an intelligent donor. Everything we want…to be there as well and that is I think people's aspirational part of it. So in that way I can say, yes they are choosing potentially a donor one up or whatever, so from that point of view. But certainly not designer in the way that we, people perceive it. Like 'I want the prettiest donor', 'No, I want the donor that looks like me.' And I think that is pretty understandable, it's less to do, it's more to do with bonding and kinship and community and family, than it is to do with designer. 100%. The people that say designer, they've got no idea the process, the psychological process that these women go through, and that's the point. It makes me so mad, that nobody wants to have egg donor babies, nobody wants to do that. You know. It comes to a place…it's a grudge purchase. You come there, you're sad, you're broken, you've been trying with your own eggs. The least you could do is let them choose a donor that looks like them. Please. You know. Don't even get me started on that cycle. (Laughs)

R: (Laughs)

P: Alright, that's all the questions for now.

R: Alright, let me show you a little bit of the portal…have a look and see… (Casual conversation)

FOLLOW UP QUESTIONS

- What are the typical questions you ask when interviewing a potential egg donor?
- What are the racial/national demographics of recipients that seek donors? I remember previously you had said that 50% of donors are Internationals and of that 70% are from Australia.
- Are pro-bono cases or clinical trials that allow for free treatment ever conducted by the clinics if you know?*
- I remember you said you did a Sociology degree for undergrad. Have alternatives to racial categorizing been considered, given that there is scientific backing for the idea that race is not hereditary? For example, would you ever consider using for example a colour wheel of complexions?
- From our initial interview, I got the sense that women who suffer with infertility endure much pain and suffering that is often ignored or side lined. What would you like to see happen in the world of infertility treatments and also society at large that may help this?
- In our initial interview, you said that recipients' pursuit of resemblance is about bonding and kinship, but also in some cases a wish to not disclose that the baby was conceived using donor eggs. What do you think of this desire not to disclose?

PARTICIPANT THREE, INTERVIEW EIGHT

R: Um, okay, so I'll just jump right in!

P: Okay, good, good…

R: Um, when you are interviewing potential donors what are the typical questions that you ask them?

R: So I have a check list that I go through. 20 points and it's not really about asking, it's about what I tell them. So uh, what I do is, for example one of the things that I tell them is, the appointments cant only happen after hours or on a Saturday, so as a donor, you would need to be able to commit time to attend the appointment. Because basically, the each, the application form asks all the questions that need to be asked. By the time we get to an interview and we get to that information session, I say, 'Based on what you have heard today, are you still willing and able to go ahead and be a donor?' And the point of that is that when they say, 'yes, I would still like to be a donor', they know what they are getting themselves into going forward.

R: Okay, I remember last time we spoke you told me that of the donors…50% are international…

P: The recipients…

R: Oops sorry. My head is on the wrong way!

P: Its fine [Smiles]

R: 50% are international and 50% are local. Of the 50% that are international, about 70% are from Australia. And so now I wanted to ask the countries that make up the other 30%?

P: Um, probably about 20% are from Africa and that's normally…Angola is our biggest.

Many are from Angola. Very few from Mozambique or Botswana. And then what remaining is Europe, UK or America. Most of those who come from Europe and America are ex-South Africans. So they know how good our medical standards are and they opt to come home for it.

R: And then do you know, if the clinics ever do any trials or instances where recipients can get free treatment?

P: Not really. No. It's just too expensive.

R: Okay and then from our first interview, I got the sense that woman that go through infertility endure a lot of pain and suffering that's often ignored or sidelined. In addition, to this, what would you like to see addressed or changed in the fertility field?

P: I think that the most important thing is education. To let women know that their fertility has an expiry date and a lot of them don't know that. So that would be the first thing. And there are gynaes that and GPs, should be generally telling patients that their fertility declines in their mid-30s, so don't leave it until your 40s to have a baby, because you are going to struggle. And it doesn't matter if you know someone whose auntie's granny whatever had a baby when she was 42. Over 35 you may struggle. So the first thing is education about fertility. Um, and then I think to let people understand, in fertility there are three main forces. There are female factors, because of the woman, male factors, or a combination of both and each of those count 30%. And then the final 10% is unknown, where they can't pinpoint why they are not conceiving. But often they will think it's the woman's fault, when actually it can be the man's fault. The most important step that you take is to go and have a fertility assessment. Find out exactly what the problem is, because if you understand the problem you can do something about it. So yah, it's really not education, people are surprisingly ill informed about fertility, how fertility works. We get women that come to us and say, 'I'm 42, but I don't look 42, I'm young, I don't smoke, I'm fit.' But your ovaries don't care. You are born with all the eggs you will ever have, so from the time you start ovulating you are losing eggs, losing eggs, losing eggs. Every single month of every year. By the time you get up to 40, you have used up most of your good eggs. Many people just don't know that so…that would be my main one. And then also obviously, access to free or state funded fertility treatments because there is a lot of people who aren't able to afford the 60, 70, 80 000 rand it costs to do treatment. Which is really sad, because I know culturally, there are some cultures which are very hard on women who are unable to have children.

R: And then lastly, I just wanted to verify, last time we spoke, we spoke about how recipients will often seek a donor who resembles them because of bonding and kinship, but also because they do not want to disclose that they used fertility treatments. From your observations do you think that is because of the stigma around infertility that couples would wish to hide it?

P: I would say that only about 30% of the reason they don't want to tell is because of stigma. The main reason is that they don't want friends or family, maybe 40%, they don't want friends or family to reject the child. So I have many women who say, 'I'm worried that my mother will love my child less, than my sister's child because that is her biological child.' So that's the one, worry that the child will be neglected. The other concern they have is that the child will hold it against them and say, 'you're not my real mom.' Something like that. And then there is a huge stigma around infertility, especially in the African community. I think I did mention to you last time 90% of my black African patients will not disclose. Whereas, 60% of my Caucasian patients will. So it's also very cultural. In fact in some…you know Muslim

people are not allowed to do egg donation. I don't know if you know that. It's against their religion because they see it as I think, as far as I understand, they see it as adultery, so they won't tell anyone for fear of being kicked out of their community. So it is complex but there certainly is a stigma and a shame involved. But more so it's about worrying that the child will be treated as less by family.

R: Okay, that's it P:

That's it! Great R:

Thank you.

BIBLIOGRAPHY

Adhikari, M. Ed. 2013. *Burdened by Race: Coloured Identities in Southern Africa*. Cape Town: UCT Press.

Aidoo, A. A. 1991. *Changes: A Love Story*. New York: The Feminist Press.

Agar, N. 1998. Liberal Eugenics. *Public Affairs Quarterly*, 12 (2): 137-155.

Allen, G. E., 1983. The Misuse of Biological Hierarchies: The American Eugenics Movement, 1900-1940. *History and Philosophy of the Life Sciences*, 5 (2): 105-128.

Allen, G. E. 1997. The Social and Economic Origins of Genetic Determinism: a case history of the American Eugenics Movement, 1900-1940 and its lessons for today. *Genetica*, 99: 7788.

Allen, K. R. 2016. Feminist Theory in Family Studies: History, Reflection and Critique. *Journal of Family Theory and Review*, 8: 207-224.

Almeling, R. 2006. 'Why do you want to be a donor': gender and the production of altruism in egg and sperm donation? *New Genetics and Society*, 25 (2): 143 – 157.

Almeling, R. 2007. Selling Genes, Selling Gender: Egg Agencies, Sperm Banks, and the Medical Market in Genetic Material. *American Sociological Review*, 72: 319-340.

Almendrala, A. 2017. 12 Celebrities Who Have Opened Up About IVF And Surrogacy*. Life – Huffington Post.* Available: https://www.huffpost.com/entry/12-celebrities-who-have-openedup-about-ivf-and-surrogacy_n_575a22cfe4b0ced23ca7a74a Accessed: October 11, 2018.

Baum, K. 2001. Golden Eggs: Towards the Rational Regulation of Oocyte Donation. *BYU Law Review*, (1): 107-166.

Bazeley, P. 2013. *Qualitative Data Analysis: Practical Strategies*. Melbourne: Sage Publications.

Becker, G., Butler, A. and Nachtigall, R. 2005. Resemblance Talk: A Challenge for Parents Whose Children Were Conceived with Donor Gametes in the US." *Social Science and Medicine* 61(6):1300–1309.

Bergmann, S. 2011. Reproductive Agency and Projects: Germans Searching for Egg Donation in Spain and the Czech Republic. *Reproductive BioMedicine Online*, 23 (5): 600608.

Birch, M., Miller, T., Mauthner, M. and Jessop, J. 2012. Introduction to the Second Edition. In Miller, M., Birch, M., Mauthner, M. and Jessop, J. Eds. *Ethics in Qualitative Research*. London: Sage Publications. pp. 1-13.

Black, E. 2003. *War Against the Weak: Eugenics and America's Campaign to Create a Master Race.* Westport, Connecticut: Dialog Press.

Bokek-Cohen, Y. and Dina Gonen, L. 2015. Sperm and simulacra: emotional capitalism and sperm donation industry. *New Genetics and Society*, 34 (3): 243-273.

Braun, V. and Clarke, V. 2006. Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, 3 (2): 77-101.

Carroll, K. 2012. Infertile? The emotional labour of sensitive and feminist research methodologies. *Qualitative Research*, 13 (5): 546-561.

Chin, H. B., Howards, P. P., Kramer, M. R., Mertens, A. C. and Spencer, J. B. 2015. Racial Disparities in Seeking Care for Help Getting Pregnant. *Paediatric Perinatal Epidemiology*, 29 (5): 416-425.

Cohen, L. 2005. Operability, Bioavailability and Exception. In Ong, A. and Collier, S. J. Eds. *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*. New Jersey: Wiley. pp.79-90.

Cohen, L., L. Manion and L. Morrison. 2011. *Research Methods in Education*. Abingdon, Oxon: Routledge.

Connelly, M. 2008. Controlling Passions. *The Wilson Quarterly*, 32 (3): 60-66.

Daniels, C. R. and Heidt-Forsythe, E. 2012. Gendered Eugenics and the Problematic of Free Market Reproductive Technologies: Sperm and Egg Donation in the United States. *Signs*, 37 (3): 719-747.

Darling, M. J. T. 2006. Reproductive and Genetic Biotechnologies: Taking Up the Challenge. *Development,* 49(1): 18-22.

Deomampo, D. 2016. Race, Nation and the Production of Intimacy: Transnational Ova Donation in India. *Positions: East Asia Cultures Critique*, 24 (1): 303-332.

Dow, K. 2017. 'The men who made the breakthrough': How the British press represented Patrick Steptoe and Robert Edwards in 1978. *Reproductive Biomedicine and Society Online*, 4: 59-67. Available: https://www.sciencedirect.com/science/article/pii/S2405661817300199 Accessed: October 8, 2018.

Dyer, S. J., Abrahams, N., Hoffman, M. and Van der Spuy, Z. M. 2002. Infertility in South Africa: women's reproductive health knowledge and treatment-seeking behaviour for involuntary childlessness. *Human Reproduction*, 17 (6): 1657-1662.

Dyer, S. J., Abrahams, N., Hoffman, M. and Van der Spuy, Z. M. 2002. 'Men leave me as I cannot have children': women's experience with involuntary childlessness. *Human Reproduction*, 17 (6): 1663-1668.

Dyer, S. J., Abrahams, N., Mokoena, N. E. and van der Spuy, Z. M. 2004. 'You are a man because you have children': experiences, reproductive health knowledge and treatmentseeking behaviour among men suffering from couple infertility in South Africa. *Human Reproduction* 19 (4): 960-967.

Dyer, S. J., Abrahams, N., Mokoena, N. E., Lombard, C. J. and Van der Spuy, Z. M. 2005. Psychological distress among women suffering from couple infertility in South Africa: a quantitative assessment. *Human Reproduction*, 20 (7): 1938–1943.

Dyer, S. J. 2007. The value of children in African countries – Insights from studies on infertility. *Journal of Psychosomatic Obstetrics & Gynecology*, 28(2): 69–77.

Dyer, S. J., Mokoena, N., Maritz, J. and Van der Spuy, Z. 2008. Motives for parenthood among couples attending a level 3 infertility clinic in the public health sector in South Africa. *Human Reproduction*, 23 (2): 352–357.

Dyer, S. J., Lombard, C., Van der Spuy, Z. 2009. Psychological distress among men suffering from couple infertility in South Africa: a quantitative assessment. *Human Reproduction,* 24 (11): 2821–2826.

Dyer, S. J., and Kruger, T. F. 2012. Assisted reproductive technology in South Africa: First results generated from the South African Register of Assisted Reproductive Techniques. *SAMJ*, 102 (3): 167-170.

Dyck, E. 2014. History of Eugenics Revisited. *CBMH/BCHM*, 31 (1): 7-16.

Elster, N. R. 2005. ART for the Masses? Racial and Ethnic Inequality in Assisted Reproductive Technologies. *De Paul Journal of Health Care Law* 9 (3): 719-734.

Erasmus, Z. 2008. Race. In Shepherd, N. and Robins, S. Eds. *New South African Keywords.* Ohio: Ohio University Press. pp. 169-181.

Erasmus, Z. 2013. Throwing the Genes: A Renewed Biological Imaginary of 'Race', Place and Identification. *Theoria*, Issue 136, 60 (3): 38 -53.

Erasmus, Z. 2017. *Race Otherwise: Forging a New Humanism for South Africa.* Johannesburg: Wits University Press.

Franklin, S. 2011. Not a flat world: the future of cross-border reproductive care. *Reproductive BioMedicine Online,* 23 (7): 814-816. Available: https: //www.sciencedirect.com/science/article/pii/S1472648311005347 Accessed: October 4, 2018.

Garuba, H. 2008. *Race in Africa: Four Epigraphs and a Commentary*. *PMLA,* 123 (5): 1640-1648.

Gates, B and M. 2017. Our 2017 Annual Letter: Warren Buffet's best investment. *Gatesnotes*. Available: https://www.gatesnotes.com/2017-Annual-Letter Accessed: September 17, 2017.

Ginsburg, F. D. and Rapp, R. 1995*. Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press.

Goldberg, H. 2009. The sex in the sperm: male infertility and its challenges to masculinity in an Israeli-Jewish context. In Inhorn, M. C., Tjornhoj-Thomsen, T., Goldberg, H. and Mosegaard, M. I. C. Eds. 2009*. Reconceiving the Second Sex: Men, Masculinity and Reproduction.* New York: Berghahn.

Gouws, A. 2017. Feminist intersectionality and the matrix of domination in South Africa. *Agenda*, 31(1):19-27. Available: DOI: 10.1080/10130950.2017.1338871 Accessed: June 23, 2019.

Greil, A. L., Slauson-Blevins, K. and McQuillan, J. 2010. The experience of infertility: a review of recent literature. *Sociology of Health and Illness*, 32 (1): 140-162.

Guendelman, S. and Stachel, L. 2011. Infertility Status and Infertility Treatment: Racial and Ethnic Disparities. *Reducing Racial/Ethnic Disparities in Reproductive and Perinatal Outcomes*, 93-117.

Hanson, F. A. 2001. Donor Insemination: Eugenic and Feminist Implications*. Medical Anthropology Quartely*, 15: 287-311.

Hargreaves, K. 2006. Constructing families and kinship through donor insemination. *Sociology of Health and Illness*, 28 (3): 261-283.

Harrison, L. 2013. The Woman or the Egg: Race in Egg Donation and Surrogacy Databases. *Genders Online Journal*, (58). Available: http://www.genders.org/g58/g58_harrison.html Accessed: September 9, 2018.

Hill Collins, P. 1998. It's All in the Family: Intersections of Gender, Race and Nation. *Hypatia*, 13 (3): 62-82.

Ikemoto, L. C. 1995. "The infertile, the too fertile, and the dysfertile." *Hastings Law Journal* 47(4):1007–1061.

Inhorn, M. C. 2006. Making Muslim Babies: IVF and Gamete Donation in Sunni vs. Shi'a Islam. *Culture, Medicine and Psychiatry*, 30: 427-450.

Inhorn, M. C. 2009. Globalization and Reproductive Tourism in the Muslim Middle East: IVF, Islam and the Middle Eastern State. In Browner, C. H. and Sargent, C. F. Eds. *Reproduction, Globalization and the State.* Durham NC: Duke University Press.

Inhorn, M. C., Tjornhoj-Thomsen, T., Goldberg, H. and Mosegaard, M. I. C. Eds. 2009. *Reconceiving the Second Sex: Men, Masculinity and Reproduction*. New York: Berghahn.

Inhorn, M. 2011. Globalization and Gametes: Reproductive 'Tourism', Islamic Bioethics, and Middle Eastern Modernity. *Anthropology and Medicine*, 18 (1): 87-103.

Inhorn, M. C. and Gurtin, Z. 2011. Cross-Border Reproductive Care: a future research agenda. *Reproductive Biomedicine Online*, 23: 665-676.

Inhorn, M. C. and Patrizio, P. 2012. Procreative tourism: debating the meaning of crossborder reproductive care in the 21st century. *Expert Rev. Obstet. Gynecol*. 7 (6): 509-511.

Inhorn, M. C. & Patrizio, P. 2015. Infertility Around the Globe: New Thinking on Gender, Reproductive Technologies and Global Movements in the 21st Century. *Human Reproduction Update*, 0 (0): 1-16.

Inhorn, M. 2015. *Cosmopolitan Conceptions: IVF Sojourns in Global Dubai*. Durham: Duke University Press.

Jain, T. 2006. Socioeconomic and Racial Disparities among Infertility Patients Seeking Care. *Fertility and Sterility*, 85 (4): 876-881.

King, N. 2004. Using templates in the thematic analysis of text. In Cassell, C. & Symon, G. Eds. *Essential guide to qualitative methods in organizational research*. London, UK: Sage. pp. 257–270

Klitzman, R. 2016. Buying and selling human eggs: infertility providers' ethical and other concerns regarding egg donor agencies. *BMC Medical Ethics*, 17 (71). DOI 10.1186/s12910016-0151-z

Kroløkke, Charlotte. 2014. West is best: Affective assemblages and Spanish oocytes. *European Journal of Women's Studies*, 21(1), pp.57–71.

Lee, K. and Tedeschi, L. G. 2015. Worldwide Human Egg Laws. *CORE (Comment on Reproductive Ethics).* Available: corethics.org Accessed: October 23, 2019.

Lewis, J. 2003. Design Issues. In Ritchie, J. and Lewis, J. 2003. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*. London: Sage. pp. 47-76.

Louw, A. 2013. Surrogacy in South Africa: Should we reconsider the current approach. *THRHR* (76): 564- 588.

MacCallum, F. and Golombok, S. 2007. Embryo Donation Families: mothers' decisions regarding disclosure of donor conception*. Human Reproduction*, 22 (11): 2888-2895.

Macionis, J. and Plummer, K. 2008. *Sociology: A Global Introduction*. 4th Edition. London: Pearson Education.

Maung, H. H. 2017. Does it matter whether infertility is a disease? *Bio News*. Available: https://www.bionews.org.uk/page_96293 Accessed: September 2, 2018.

Maung, H. H. 2018. Ethical problems with ethnic matching in gamete donation. *J Med Ethics,* 45: 112-116.

Moll, T. 2018. Biological relatives: IVF, stem cells, and the future of kinship. *Anthropology Southern Africa* 38(1-2): 149-151. Available: DOI: 10.1080/23323256.2015.103043 Accessed: October 7, 2019.

Moll, T. 2019. Making a Match: Curating Race in South African Gamete Donation. *Medical Anthropology.* DOI: 10.1080/01459740.2019.1643853 Accessed: October 21, 2019.

Motsemme, N. 2002. Gendered Experiences of Blackness in Post-Apartheid. *Social Identities*, 8 (4): 647-673.

Murray, C. A. and Herrnstein, R. J. 1994. *The Bell Curve: Intelligence and class structure in American Life*. New York: Simon and Schuster.

Myers, A. M. and Rothblum, E. D. 2004. Chapter 5: Coping with Prejudice and Discrimination Based on Weight. In Chin, J. L. Ed. *The Psychology of Prejudice and Discrimination: Volume 4, Disability, Religion, Physique and Other Traits.* London: Praeger Publishers.

Nachtigall, R. D. 2006. International Disparities in Access to Infertility Services. *Fertility and Sterility*, 85 (4): 871-875.

Nahman, M. R. 2013. *Extractions: An Ethnography of Reproductive Tourism*. Houndsmills, Basingstoke: Palgrave MacMillan.

Nowell, L. S., Norris, J. M., White, D. E. and Moules, N. J. 2017. Thematic Analysis: Striving to Meet the Trustworthiness Criteria*. International Journal of Qualitative Methods*, 16: 1-13.

O'Hara, L. L. and Shue, C. K. 2014. A Sensitive Question: Asking about Race in a Research Interview. *The Qualitative Report*, 19 (88): 1-21.

Pande, A. 2010. Commercial Surrogacy in India: Manufacturing a perfect mother-worker. *Signs: Journal of Women in Culture and Society*, 35(4): 969-992.

Pande, A. 2014. *Wombs in Labour: Transnational Commercial Surrogacy in India*. New York: Columbia University Press.

Pande, A. 2016. Global Reproductive Inequalities, Neo-eugenics and Commercial Surrogacy in India. *Current Sociology*, 64 (2): 244-258.

Pande, A. and Moll, T. 2018. Gendered bio-responsibilities and travelling egg providers from South Africa. *Reproductive BioMedicine and Society Online*, 6: 23-33.

Pande, A. 2018. Cross Border Repro-Flows and the Reproduction of White Desirability [Forthcoming].

Payne, J. G. 2015. Reproduction in transition: cross-border egg donation, biodesirability and new reproductive subjectivities on the European Fertility Market. *Gender, Place and Culture*, 22 (1): 107-122.

Perkowitz, S. 2017. How to Understand the Resurgence of Eugenics. *Jstor Daily*. Available: https://daily.jstor.org/how-to-understand-the-resurgence-of-eugenics/ Accessed: October 4, 2018.

Pfeffer, N. 2011. Eggs-ploiting women: a critical feminist analysis of the different principles in transplant and fertility tourism. *Reproductive Biomedicine Online*, 23, 634-641.

Pilcher, H. 2006. Fertility on a Shoestring*. Nature*, 442: 975-977.

Quinn, M. and Fujimoto, V. 2016. Racial and Ethnic Disparities in assisted reproductive technology access and outcomes. *Fertility and Sterility*, 105 (5): 1119-1123.

Quiroga, S. S. 2007. “Blood Is Thicker than Water: Policing Donor Insemination and the Reproduction of Whiteness”. *Hypatia*, 22 (2): 143-161.

Roberts, D. E. 1996. Race and the New Reproduction. *Faculty Scholarship.* Paper 1154. Available: http://scholarship.law.upenn.edu/faculty_scholarship/1154 Accessed: January 23, 2017.

Roberts, D. 2009. Race, Gender and Genetic Technologies: A New Reproductive Dystopia? *Faculty Scholarship*. Paper 1421. Available: http://scholarship.law.upenn.edu/faculty_scholarship/1421 Accessed: January 23, 2017.

Roberts, D. 2011. *Fatal Invention: How Science, Politics and Big Business Re-create Race in the Twenty-First Century*. New York: The New Press.

Roberts, E. 2013. Assisted existence: an ethnography of being in Ecuador. *Journal of the Royal Anthropological Institute*, 19: 562-580.

Roberts, E. 2012. *God's Laboratory: Assisted Reproduction in the Andes*. Berkeley: University of California Press.

Russell, C. 2015. The Race Idea in Reproductive Technologies: Beyond Epistemic Scientism and Technological Mastery. *Bioethical Inquiry* (12): 601–612.

Ryan, M. A. 2009. The Introduction of Assisted Reproductive Technologies in the “Developing World”: A Test Case for Evolving Methodologies in Feminist Bioethics. *Signs: Journal of Women in Culture and Society*, 34 (4): 805-825.

Sandel M. J. 2004. The Case Against Perfection: Whats wrong with designer children, bionic athletes and genetic engineering. *The Atlantic Online*. Accessed (28 May 2018).

Sarojini, N., Marwah, V. and Shenoi, A. 2011. Globalization of Birth Markets: a case study of assisted reproductive technologies in India. *Globalization and Health*, 7(27).

Schurr, C. 2017. “From biopolitics to bioeconomies: The ART of (re)producing white futures in Mexico’s surrogacy market.” *Environment and Planning D: Society and Space* 35 (2): 241262.

Selden, S. 2005. Transforming Better Babies into Fitter Families: archival resources and the history of American eugenics movement, 1908-1930. *Proceeding of the American Philosophical Society*, 149 (2): 199-225.

Shanley, M. L. and Asch, A. 2009. Involuntary Childlessness, Reproductive Technology, and Social Justice: The Medical Mask on Social Illness. *Signs: Journal of Women in Culture and Society* 34(4): 851-874.

Shaw, A. E. 2006. *The Embodiment of Disobedience: Fat Black Women’s Unruly Political Bodies.* Oxford: Lexington Books.

Shaw, M. K. 2018. The Familial and the Familiar: Locating Relatedness in Columbian Donor Conception. *Medical Anthropology*, 37 (4): 280-293.

Shehab, D., Duff, J., Pasch, L. A., Mac Dougall, K., Scheib, J. and Nachtigall, R. 2008. How parents whose children have been conceived with donor gametes make their disclosure decision: contexts, influences, and couple dynamics. *Fertility and Sterility*, 89 (1): 179-187.

Smith, D. 2009. Chapter One: Key Concepts and Theories About ‘Race’. In Bhui, S. H. Ed. *Race and Criminal Justice.* London: Sage Publications. pp. 9-29.

Speier, A. 2016*. Fertility Holidays. IVF Tourism and the Reproduction of Whiteness*. New York: New York University Press.

Strings, S. 2015. Obese Black Women as “Social Dead Weight”: Reinventing the “Diseased Black Woman”. *Signs: Journal of Women in Culture and Society*, 41 (1): 107-130.

Strode, A., Mthembu, S. and Essack, Z. 2012. “She made up a choice for me”: 22 HIVpositive women’s experiences of involuntary sterilization in two South African provinces. *Reproductive Health Matters*, 20 (39): 61-69.

Suter, S. M. 2007. A Brave New World of Designer Babies? *Berkeley Technology Law Journal*, 22 (2): 897-969.

Tabong, P. T. and Adongo, P. B. 2013. Infertility and childlessness: a qualitative study of the experiences of infertile couples in Northern Ghana. *BMC Pregnancy and Childbirth*, 13 (72). Available: http://www.biomedcentral.com/1471-2393/13/72 Accessed: August 8, 2018.

Thompson, J. E. 2013. The Eggsploitation of the United States’ Organ and Egg Donation Systems. *Valparaiso University Law Review*, 48 (1): 469-518.

Van Amsterdam, N. 2012. Big fat Inequalities, thin privilege: an intersectional perspective on body size. *European Journal of Women’s Studies*, 0 (0): 1-15.

Van Niekerk, C. 2017. Assisted Reproductive Technologies and the Right to Reproduce under South African Law. *PER/PELJ*, (20). Available: http://dx.doi.org/10.17159/17273781/2017/v20n0a1305 Accessed: October 4, 2018.

Walther, C. S. 2014. Skin tone, biracial stratification and tri-racial stratification among egg donors. *Ethnic and Racial Studies*, 37(3): 517-536. Available: http://dx.doi.org/10.1080/01419870.2012.696666 Accessed: August 8, 2018.

Wellings, K., Branigan, P. & Mitchell, K. 2000. Discomfort, Discord and Discontinuity as Data: Using Focus Groups to Research Sensitive Topics. *Culture, Health and Sexuality*, 2 (3): 255-267.

Whittaker, A. and Speier, A. 2010. “Cycling Overseas”: Care, Commodification, and Stratification in Cross-Border Reproductive Travel. *Medical Anthropology*, 29 (4): 363-383.

Winant, H. 2000. Race and Race Theory. *Annual Review of Sociology*, 26: 169-185.

Wintour, P. 2018. Emmanuel Macron: ‘More choice would mean fewer children in Africa.’ *The Guardian*. Available: https://www.theguardian.com/globaldevelopment/2018/sep/26/education-family-planning-key-africa-future-emmanuel-macronun-general-assembly Accessed: October 10, 2018.